EXHIBIT 1
DATE 1/15/13
HB

THE MONTANA MEDICAID PROGRAM

Montana Department of Public Health and Human Services Report to the 2013 Legislature

State Fiscal Years 2011/2012

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

PO Box 4210 ♦ Helena, MT 59602 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Steve Bullock, Governor

Richard H. Opper, Director

January 15, 2013

Dear Legislators:

The Department of Public Health and Human Services (DPHHS) is pleased to provide the Montana Medicaid Program Report to the 2013 Legislature, as is required by Montana law.

The Montana Medicaid program helps Montanans all across this state to be more self sufficient. Medicaid is a joint federal-state program that pays for a broad range of medically necessary health care and long-term care services for certain low income populations. DPHHS administers the program in a partnership with the federal Centers for Medicare and Medicaid Services (CMS).

DPHHS has prepared this overview to provide basic information for your use as a starting point in understanding the Medicaid program. The report outlines the eligibility process, including resource limit requirements, and the actual enrollment of and benefits paid to the separate eligible populations. Eligibility is primarily determined by staff in Offices of Public Assistance throughout the state in most counties, who work to ensure that the determination process runs as efficiently as possible.

The overview explains Medicaid benefits; enrollment and expenditures by county; the number of participating providers and claims they submitted; and a summary of the rate setting process. There is also a section on waivers. DPHHS has requested several Medicaid waivers from CMS in order to better customize services for key populations. These waivers have allowed us to dramatically improve the lives of people participating in the Montana Medicaid program, by providing cost efficient service in their homes and communities.

Tribal activities are another key piece of this report. DPHHS contracts with Indian Health Services and Tribal health departments for services in many Tribal communities.

Thank you for taking the time to better understand the Medicaid program by reading this in its entirety. If you have any questions, or if we can provide additional information, please feel free to contact me at 444-4084 or mdalton@mt.gov.

Sincerely,

Mary E. Dalton

Mary E. Dalton
Montana State Medicaid Director

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The Montana Medicaid Program
Report to the 2013 Legislature

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

Basic Objectives:

- Promote the maintenance of good health of Medicaid eligible persons
- Assure that Medicaid eligible persons have access to necessary medical care
- Assure that the quality of care meets acceptable standards
- Promote the appropriate use of services by Medicaid eligible persons
- Assure that services are provided in the most cost effective manner
- Assure that only medically necessary care is provided
- Assure that the Medicaid program is operated within legislative appropriation
- Assure that prompt and accurate payments are made to providers
- Assure that accurate Medicaid program and financial information is available for management on a timely basis
- Assure that confidentiality and privacy of client information is maintained at all times
- Promote the appropriate utilization of preventive services

MEDICAID PROGRAM OVERVIEW

The Montana Medicaid program is a joint federal-state program. The State administers the program in partnership with the federal Centers for Medicare and Medicaid Services (CMS). States are required to provide the same amount, duration, and scope of services to all people who receive a Medicaid benefit unless they have a waiver. The State is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. As a general rule, the Montana Medicaid program has flexibility to: 1) design our own eligibility package; 2) design our own benefit package; and 3) determine provider reimbursement within certain guidelines established by CMS. The Montana Medicaid benefits package meets the federal requirements.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the 2012 matching rate is approximately 66% federal and 34% state funds. Simply stated, if DPHHS receives 34 cents in general funds, the 34 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as services provided in Indian Health Service Facilities at 100% federal dollars; for family planning services at 90% federal; and services through the breast and cervical cancer program at 78%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

MEDICAID ELIGIBILITY

The rules governing Medicaid eligibility changed with the passage of the Affordable Care Act. As of March 2010, a state can no longer decrease eligibility for Medicaid below the level in place as of that date. Montana can still choose to add eligibility categories but we cannot decrease either the number of categories/groups that we cover nor can we decrease the level of poverty that we provide coverage for until January 1, 2014.

These are the different groups/populations that Montana provides Medicaid coverage for:

Children – Medicaid is the largest provider of health care coverage for children in the State of Montana. During State Fiscal Year 2011, there were an average of 68,259 children enrolled in Medicaid per month; of these 3,092 were disabled children and 5,568 were part of the Healthy Montana Kids, Medicaid enrolled CHIP funded group. For State Fiscal Year 2012 there were an average of 70,558 children with 3,088 disabled children and 6,365 part of the HMK Medicaid enrolled CHIP funded group. Children are primarily covered by Medicaid under one of the following three programs:

- Healthy Montana Kids Plus - Children up to the age of 19 in families with countable income equal to or less than 133% of the Federal Poverty Level (FPL). There is no resource test for these children.

- Infants - Children born to women who are receiving Medicaid at the time of birth automatically qualify for Medicaid coverage through the month of their first birthday. There is no income or resource test for this coverage.
- Subsidized Adoption and Foster Care - Children who are eligible for an adoption subsidy through the Department are automatically eligible for Medicaid coverage. This coverage can continue through the month of the child's 21st birthday. Children who are placed into licensed foster care homes by the Child and Family Services Division are eligible for Medicaid.

Pregnant Women – Medicaid must be provided to eligible pregnant women with countable income equal to or less than 150% FPL (increased from 133% FPL in July 2007) and countable resources that do not exceed $3000. The coverage extends for 60 days beyond the birth of their child.

2011 Federal Poverty Levels & Gross Monthly Income

Family Size	Pregnant Woman 150% FPL	HMK Plus 133% FPL	Child 100% FPL
1	$1,354	$1,200	$903
2	$1,821	$1,615	$1,214
3	$2,289	$2,029	$1,526
4	$2,756	$2,444	$1,838
Resource Test	<=$3,000	No Test	No Test

Families with Dependent Children – Parents or related caretakers (grandparents, aunts/uncles, etc.) whose countable income is below the Family Medicaid income level and whose countable resources do not exceed $3000 may receive Medicaid. TANF cash assistance eligibility must be determined separately from Medicaid.

Family-Transitional Medicaid - Under certain conditions, families are eligible for up to 12 months of extended Medicaid coverage after their eligibility for Section 1931 Medicaid coverage ends due to new or increased earned income. This coverage, called Family-Transitional Medicaid, is not dependent on income, and there is no resource limit. The family must meet all other eligibility criteria for the entire 12 months.

Aged – Individuals who are age 65 or older and whose countable income is within allowable guidelines and whose resources do not exceed $2000 for an individual or $3000 for a couple may be eligible for Medicaid.

Blind/Disabled – Individuals who have been determined to be blind or disabled using Social Security criteria; whose income is within allowable limits; and whose resources do not exceed $2000 for an individual or $3000 for a couple may be eligible for Medicaid.

Income limits for the aged, blind and disabled populations are $674 per month for an individual and $1011 for a couple.

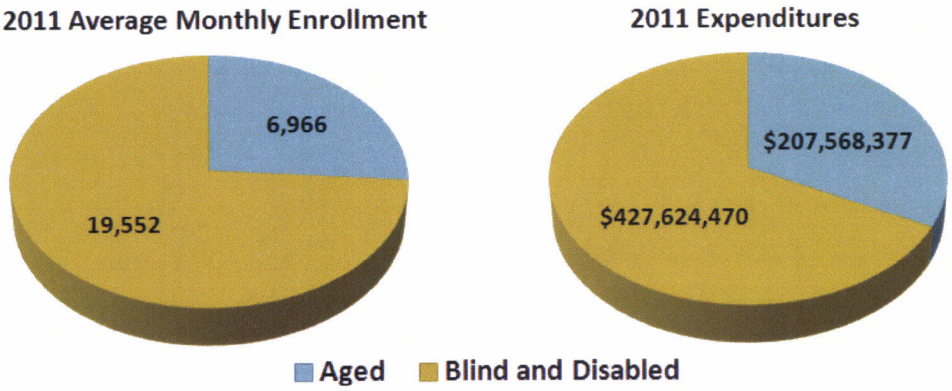
People Who Are Aged, Blind, or Disabled Receiving Supplemental Security Income (SSI) - Low income aged, blind, and disabled persons make up a large group within the Medicaid program. Many aged, blind, and disabled clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. Medicaid is critical to maintaining their access to medical care and thereby supports a higher level of independence, often reducing the need for more costly medical and support services. New SSI income standards for 2012 are $698/$1048.

2011

Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$674
2	$3,000	$1,011

Persons who are aged, blind, or disabled and whose income and resources are below federal Supplemental Security Income (SSI) limits may receive both SSI cash benefits and Medicaid, or they may receive Medicaid only. The Department's Disability Determination Bureau determines disability status for the SSI program. Aged, blind, or disabled persons with income above the SSI standards may be eligible for Medicaid under the medically needy program.

Enrollment and Expenditure Comparison Aged and Blind / Disabled



Note that graphs above do not include Medicare Savings Plan Only clients or expenditures.

Breast and Cervical Cancer Treatment - This is a program for women who are diagnosed with breast or cervical cancer or a precancerous condition of the breast or cervix. To be eligible, a woman must be under 65 years old, not have insurance that is considered to be 'creditable coverage,' meet citizenship or qualified alien requirements, be a Montana resident, and have been screened through the Montana Breast and Cervical Health Program. Countable income cannot exceed 200% of the Federal Poverty Level and there is no resource test.

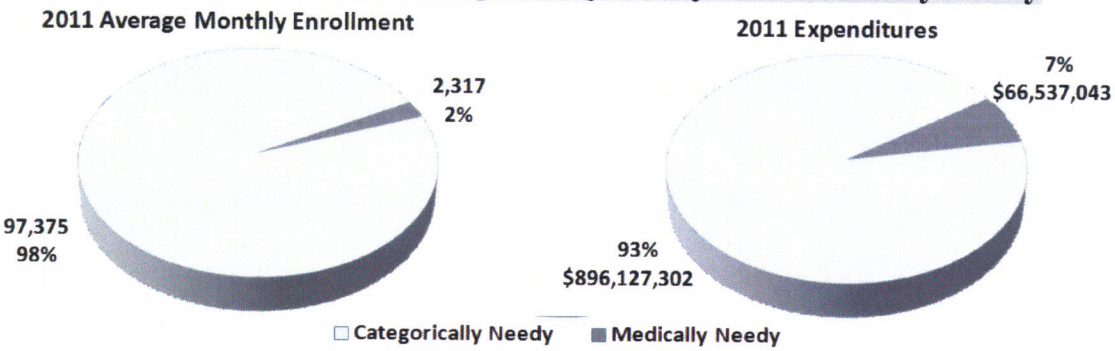
Montana Medicaid for Workers with Disabilities (MWD) –Montana implemented MWD effective July 1, 2010, based on provisions of the Balanced Budget Act of 1997 (BBA). MWD allows certain current and former SSDI and SSI recipients who may not be financially eligible for Medicaid to pay affordable premiums for Medicaid coverage. Individuals must be employed (either through an employer or self-employed) to be considered for this program. MWD resource standards are significantly higher than many other Medicaid programs – $8000 for an individual and $12,000 for a couple; the countable income limit is 250% of the Federal Poverty Level.

Medically Needy – This is coverage for certain individuals or families whose income exceeds the program standards but who have a significant medical need. The individual or family pays the difference between their countable income and the Medically Needy Income Level toward medical expenses each month. This difference is called an incurment or spenddown and can be met by making cash payments to the Department, incurring medical bills or a combination of the two. The resource limit is $2000 for an individual, and $3000 for a couple or family. In Montana, the aged, blind, disabled, children and pregnant women are covered under the medically needy program. Note that the income standards are tested against countable income after deductions that include earned income deductions and $100 per household general income deduction

State Fiscal Year 2011 Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
**$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples.		

Comparison between Categorically Needy and Medically Needy



Note that graphs above do not include HMK (CHIP) or Medicare Savings Plan clients or expenditures.

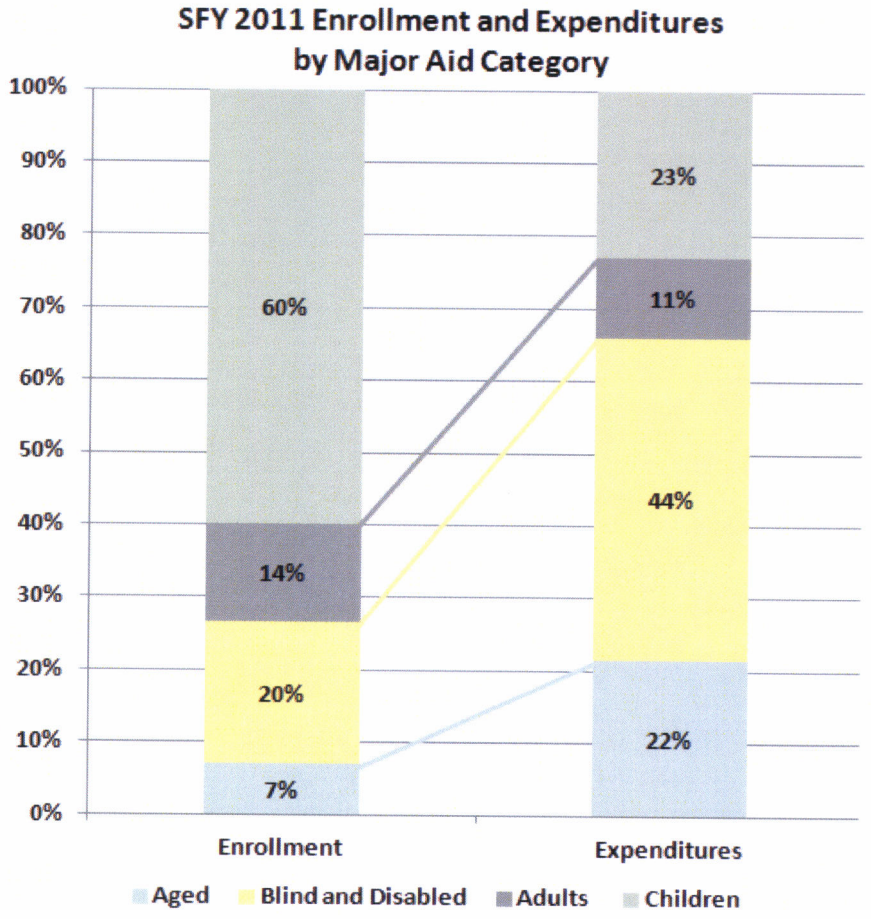
Summary of Medicaid Enrolled Persons for State Fiscal Year 2011
July 1, 2010 - June 30, 2011

Beneficiary Characteristic	Average Monthly Enrollment: All	Aged	Blind & Disabled	Adults	Children	% of Medicaid Total	% of Montana Population
Total	**99,692**	**6,966**	**19,552**	**13,575**	**59,599**	**100%**	
Age							
0 to 1	5,921	0	70	0	5,851	6%	1%
1 to 5	22,793	0	629	0	22,164	23%	6%
6 to 18	33,976	0	2,392	0	31,584	34%	16%
19 to 20	1,750	0	524	1,226	0	2%	3%
21 to 64	28,129	0	15,780	12,349	0	28%	58%
65 and older	7,123	6,966	157	0	0	7%	15%
Gender							
Male	44,864	2,083	9,635	3,064	30,082	45%	50%
Female	54,828	4,883	9,917	10,511	29,517	55%	50%
Race							
White	76,181	6,180	16,303	9,453	44,245	76%	90%
Native American	21,975	712	2,969	3,948	14,346	22%	6%
Other	1,536	74	280	174	1,008	2%	4%
Assistance Status*							
Medically Needy	2,317	1,015	1,244	4	54	2%	
Categorically Needy	97,375	5,951	18,308	13,571	59,545	98%	
Medicare Status							
Part A and B	13,807	6,641	7,061	104	1	14%	
Part A only	66	11	42	13	0	0%	
Part B only	291	290	1	0	0	0%	
None	85,528	24	12,448	13,458	59,598	86%	
Medicare Saving Plan (not included in total)							
QMB Only	4,878	2,973	1,905	0	0		
SLMB - QI Only	2,276	2,276	0	0	0		

* Medically Needy clients are responsible for their medical bills each month until they have incurred enough medical expenses equal to the difference between their countable income and the Medically Needy income level.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees Medicaid pays for Medicare premiums, co-insurance, and deductibles. For SLMB - QI only enrollees Medicaid pays for Medicare Premiums.

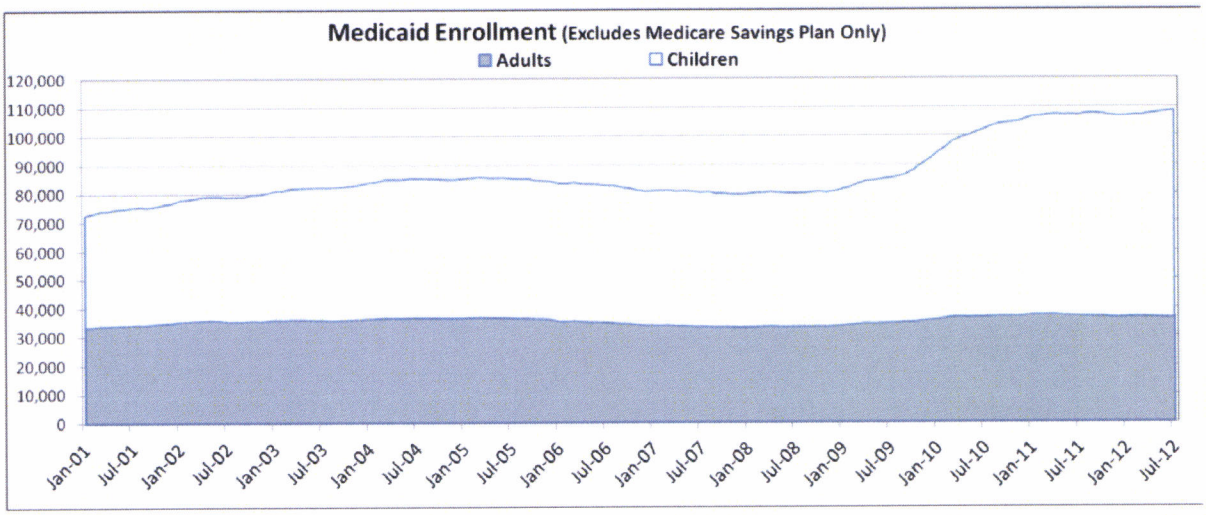
The column in the above chart "% of Montana Population" shows the percentage of Montana population for that beneficiary characteristic. For example 50% of Montana's population is female, but 55% of the total Medicaid population in Montana is female.



The chart shows Medicaid enrollment in 2011 by aid category. The Aged and Disabled are a relatively small percentage of the entire Medicaid population, but account for a high percentage of the Medicaid funds expended. Conversely, Children represent more than half of the Medicaid population but account for approximately one-quarter of the cost.

SFY 2011 Enrollment and Expenditures by Major Aid Category

Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	6,966	7%	$207,568,377	22%
Blind and Disabled	19,552	20%	$427,624,470	44%
Adults	13,575	14%	$106,220,908	11%
Children	59,599	60%	$221,250,590	23%
Total	99,692	100%	$962,664,345	100%


Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
120,000
110,000
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
Jul-07
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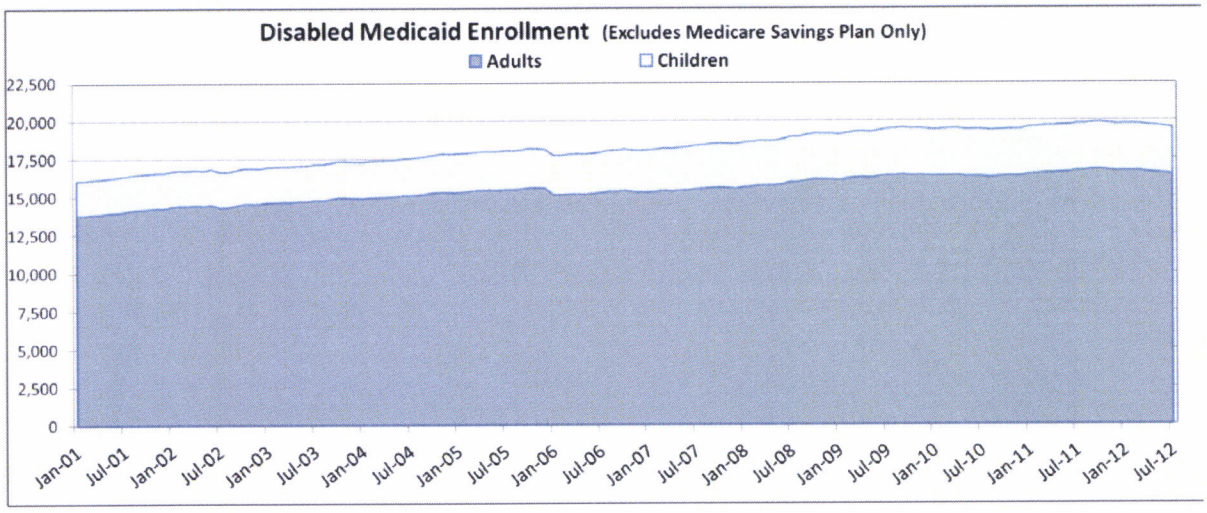
Jul-08
Jan-09
Jul-09
Jan-10
Jul-10
Jan-11
Jul-11
Jan-12
Jul-12


Disabled Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
22,500
20,000
17,500
15,000
12,500
10,000
7,500
5,000
2,500
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
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Jan-10
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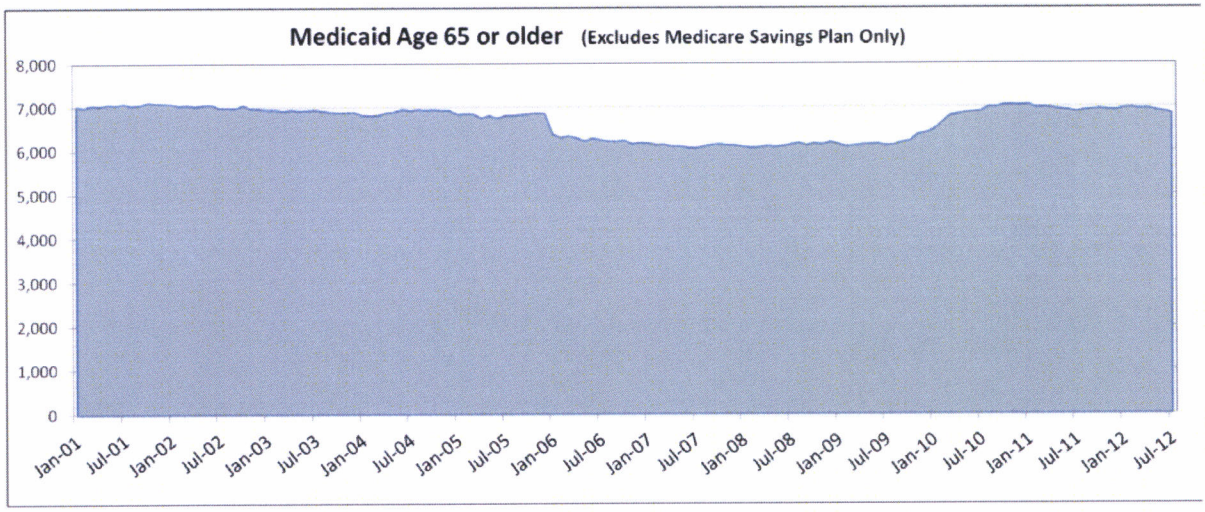
Jan-11
Jul-11
Jan-12
Jul-12


Medicaid Age 65 or older (Excludes Medicare Savings Plan Only)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
Jul-06
Jan-07
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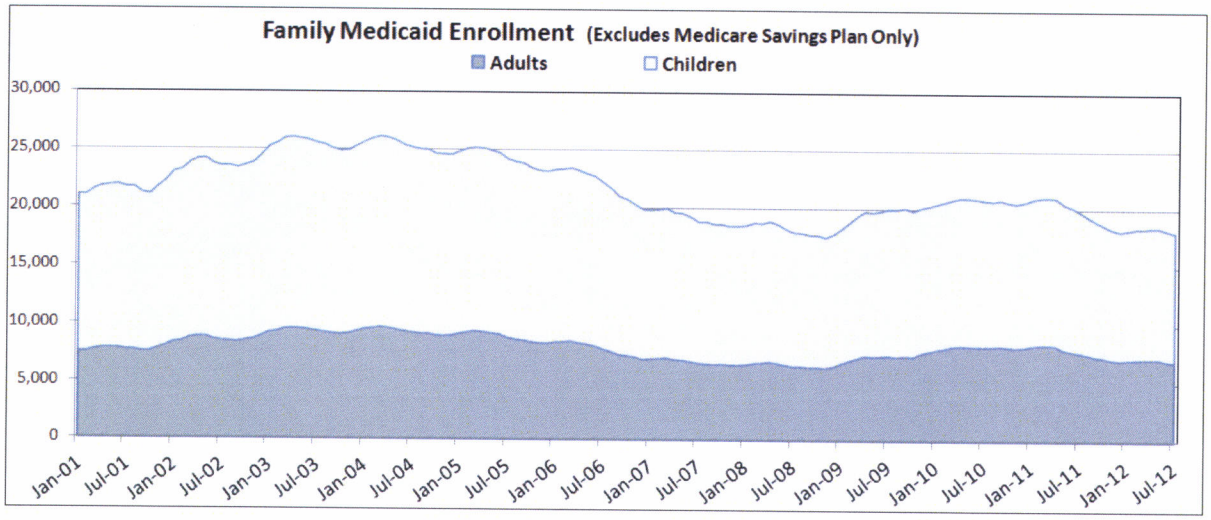
Jul-12


Family Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
30,000
25,000
20,000
15,000
10,000
5,000
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
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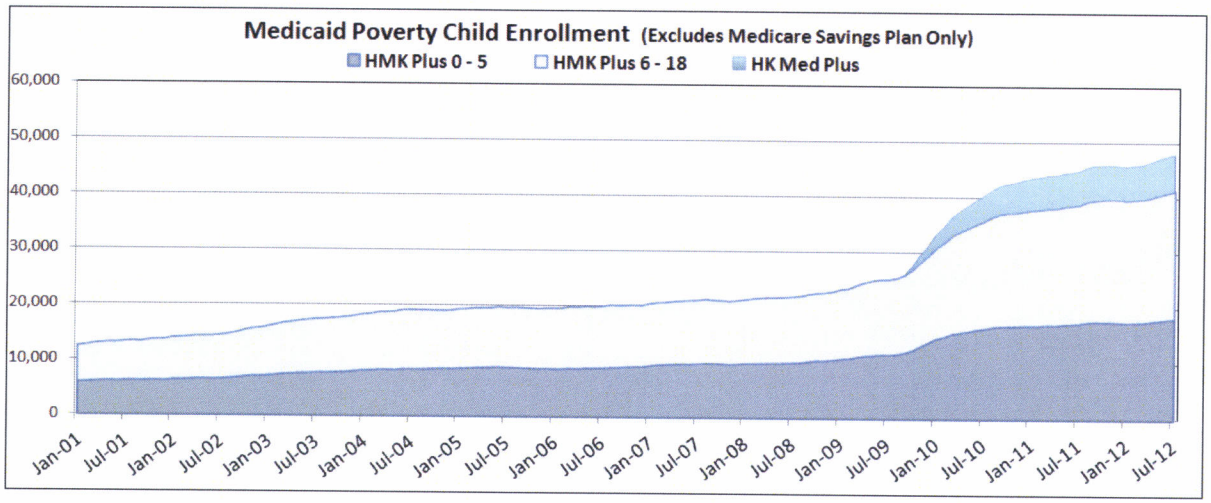
Medicaid Poverty Child Enrollment (Excludes Medicare Savings Plan Only)
HMK Plus 0 - 5
HMK Plus 6 - 18
HK Med Plus
60,000
50,000
40,000
30,000
20,000
10,000
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
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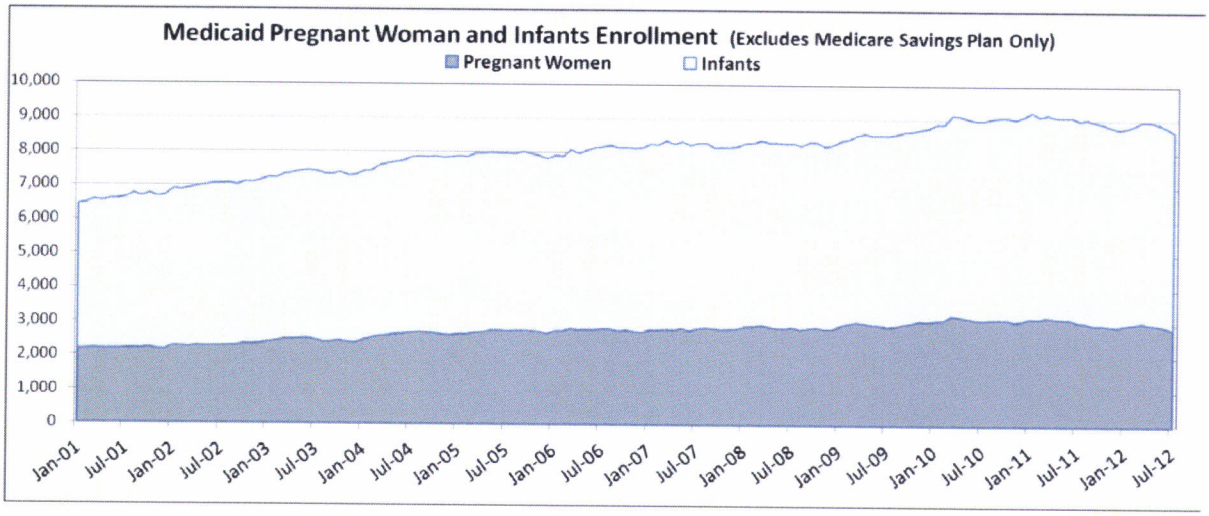
Medicaid Pregnant Woman and Infants Enrollment (Excludes Medicare Savings Plan Only)
Pregnant Women
Infants
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Jan-01
Jul-01
Jan-02
Jul-02
Jan-03
Jul-03
Jan-04
Jul-04
Jan-05
Jul-05
Jan-06
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Jul-12

MEDICAID WAIVERS

State Medicaid programs may request from the Centers for Medicare and Medicaid Services (CMS) a waiver(s) of certain federal Medicaid requirements that are found in the Social Security Act. A common public misconception is that any portion of the Medicaid program can be waived by CMS. In reality, only certain requirements such as statewideness, freedom of choice, and comparability of eligibility and/or benefits can be waived. Waivers are also limited in that they must always be cost neutral to the federal government.

The following is a brief description of the three types of waivers that Montana operates:

- **Section 1115 waivers** authorize experimental, pilot, or demonstration project(s). The Secretary of Health and Human Services has complete discretion as to whether an 1115 waiver is granted. This kind of waiver is granted only when the Secretary feels that a state will demonstrate something that is of interest in promoting the objectives of the Medicaid program. Our experience has been that CMS approval of these waivers takes several years. An 1115 waiver can be used to expand eligibility for Medicaid. The number and type of services can either be limited or expanded under this type of waiver.

- **Section 1915(b) waivers** allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers available:
  (b)(1) mandates Medicaid enrollment into managed care
  (b)(2) utilize a "central broker"
  (b)(3) uses cost savings to provide additional services
  (b)(4) limits the number of providers for services

- **Section 1915(c) waivers** are referred to as Medicaid Home and Community-Based Services (HCBS) waivers. They are alternatives to providing long-term care in an institutional setting (Medicaid defines an institution as a nursing facility, hospital, or Intermediate Care Facility for the Mentally Retarded.) A 1915(c) waiver enables a state to pay for an expanded array of medical care and support services that assist people to continue to live in their homes and/or communities. These waivers also allow a state, if it wishes, to count only the income of the affected individual rather than that of the whole family when determining eligibility.

- States also have the discretion to provide a combination 1915(b) and 1915(c) waiver.

Montana operates a number of different waivers in order to better customize services for key populations. A brief description of our current waivers is found on the next several pages:

1115 Basic Medicaid Waiver – Health Resources and Addictive and Mental Disorders Division – Approved in 1996, this waiver offers a limited benefit package of services to Medicaid eligible adults, age 21 to 64. Participants cannot be pregnant or disabled, with the exception that is noted below. Participants receive a basic package of Medicaid benefits that excludes: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids. DPHHS recognizes there may be situations where these excluded services are necessary in an emergency situation, when they prevent more costly care, or when they are essential to obtain or maintain employment. In these instances, excluded services may be provided at the State's discretion. Examples of discretionary circumstances include coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen.

Effective December 2010, the state received approval for the long-awaited "HIFA" waiver. CMS approved the addition of up to 800 individuals who previously qualified for the state funded Mental Health Services Plan. Eligible participants must be at least 18 years of age and have schizophrenia or bipolar disorder. Under the "MHSP" portion of the Basic Waiver, individuals are eligible to receive medical care as well as psychiatric services. Federal savings generated from the Basic Medicaid Waiver Able Bodied population described above are used to maintain federal cost neutrality.

In SFY 2011 the waiver served a total of 17,848 individuals. 17,512 were Able Bodied Adults and 336 were individuals with schizophrenia or bipolar disorder. SFY 2011 total state and federal waiver expenditures were $26,427,915; $950,396 of this amount was for individuals with schizophrenia or bipolar disorder. In SFY 2012, 898 individuals with schizophrenia or bipolar disease were served.

1115 Plan First Waiver – Health Resources Division - This waiver covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of STDs. Eligible women must be:

- Age 19 through 44
- Able to bear children and not presently pregnant
- Have annual household income up to 200% Federal Poverty Level
- Have no other family planning health coverage (i.e. through insurance)

This program is limited to 4,000 women at any given time. CMS notified the department of the approval of this waiver on May 30, 2012 and this waiver is approved through December 31, 2013. 888 women were enrolled as of October 2012.

1915(b) Waiver Passport to Health - Health Resources Division – Passport to Health is the primary care case management program in which most Medicaid and HMK *Plus* eligible individuals are enrolled. A client chooses a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care.

Care management offered under the waiver enhances care by minimizing ineffective or inappropriate medical care. The waiver is operated in all 56 counties and involves 71 percent of all Montana Medicaid members. Quality, access to care, and health outcomes are continuously monitored, tracked, and reported. Clients and providers report satisfaction with these care management programs.

This waiver also includes Team Care, a program for individuals identified with inappropriate or excessive utilization of health care services. Individuals are enrolled in Team Care for at least 12 months and receive services from one pharmacy and one medical provider.

1915 (b) Waiver – Health Improvement Program - Health Resources Division – The Health Improvement Program is an enhanced primary care case management program, administered in partnership with community health centers and a Tribal provider. High-cost, high-risk Medicaid and HMK *Plus* clients are identified by Medicaid through the use of predictive modeling software and provider referrals. Care managers employed by community health centers or the tribe provide in-person and telephonic health care management services to improve health outcomes and increase the ability of members to self-manage their health conditions.

This waiver includes Nurse First, a 24/7 nurse advice line available to all Medicaid and HMK *Plus* clients. The advice line is operated by a vendor and directs callers to the most appropriate level of care: self-care, provider visit, or emergency department visit.

1915 (c) HCBS Children's Autism Waiver - Developmental Services Division - CMS approved the waiver on January 1, 2009 to serve 50 Montana children age 15 months through 7 years old with autism and adaptive behavior deficits. This children's autism waiver provides early intervention based upon applied behavioral analysis (ABA) training models. Children receive about 20 hours of intensive training per week that is focused on improving skills in the areas of communication, socialization, academics, and activities of daily living while reducing maladaptive behaviors. The waiver serves 50 children per year. Children may be served for a maximum of three years. Seven agencies across the state provide program design and training, case management services, and other supports to enrolled children and their families.

Medicaid reimbursement in SFY 2012 was $1,333,679. Approximately 72 children (under the age of 5) are currently on the waiting list for Children's Autism Waiver services.

1915 (c) HCBS Comprehensive Services Waiver for Individuals with Developmental Disabilities - Developmental Services Division - This waiver for people with Developmental Disabilities (DD) was initiated in 1981. It was one of the first waivers in the country to provide community based services to persons needing DD services. It served 347 children and 1831 adults in SFY 2011. The majority of reimbursement for adults goes to group home, supported living, work/day, and transportation services. Children's services include caregiver training and support and children's case management. Specialized services available under this waiver include the following: psychological services, board certified behavioral analyst (BCBA) consultation, personal care, homemaker, respite, occupational therapy, physical therapy, speech therapy, environmental modifications, nutritional evaluations, private duty nursing, meals,

personal emergency response systems (PERS), and respiratory services. The average cost per person served in this waiver was $39,753 in SFY011.

1915 (c) HCBS Community Supports Waiver - Developmental Services Division - The waiver was initially approved by CMS in 2001. Many persons in this waiver live at home. Services are often purchased to help unpaid primary care givers better meet the needs of an adult family member with a developmental disability. Waiver services include: homemaker, personal care, respite, residential habilitation, day habilitation, prevocational training, supported employment, environmental modifications, transportation, specialized medical and adaptive equipment, adult companion, private duty nursing, social/leisure/recreation opportunities, personal emergency response systems (PERS), health/safety supports and educational services. This waiver served 273 adults (age 18 years and up) in SFY 2011. Cost plans are capped at $7,800/person.

1915(b)(4) and 1915(c) The Montana Big Sky Waiver - Senior and Long Term Care Division - This is a concurrent or combination 1915(b)(4) and 1915(c) waiver (see earlier description of Medicaid Waivers). The HCBS Waiver, serving the elderly (age 65 and older) and people with physically disabilities started in 1982. The program recognizes that many individuals at risk of being placed in institutional settings can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. To qualify a person must be financially eligible for Medicaid and meet the program's level of care requirements in a nursing facility or hospital. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer. This waiver has an extensive menu of services which includes case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, health and wellness, consumer directed services and personal emergency response systems. On July 01, 2011, Montana added the 1915 (b) component, which limits the number of case management teams available, and changed the name to the Montana Big Sky Waiver. In 2012 more than 2,500 individuals received Montana Big Sky Waiver funded services.

The 1915(c) HCBS Big Sky Bonanza Waiver - Senior and Long Term Care Division- This waiver which began in 2006, was incorporated into the Montana Big Sky Waiver on June 30, 2011.

1915(c) HCBS Severe Disabling Mental Illness Waiver (SDMI) - Addictive and Mental Disorders Division - Implemented in December 2006, this waiver allows Medicaid reimbursement for community-based services for individuals who are 18 years of age or older with SDMI who meet certain criteria for nursing home level of care. The waiver's 155 slots in SFY2011 are distributed among five geographic core areas including Billings, Great Falls, Missoula, Helena and Butte plus surrounding counties for each. In each site, services are coordinated by a team that is made up of a registered nurse and a social worker. Services provided to persons enrolled in the SDMI waiver include case management, wellness recovery action plan (WRAP), illness management and recovery (IMR) program, non-medical transportation, specialized medical equipment and supplies, personal emergency response, adult day care, respite, private duty nursing, prevocational services, supportive employment, additional

occupational therapy, habilitation aide, substance use related disorders services, residential and day habilitation, supportive living, personal assistance and specially trained attendants, psychosocial rehabilitation, consultation, community transition, health and wellness, and pain and symptom management.

1915(c) Look Alike - Alternative to PRTF Demonstration Waiver/Grant for Youth with Serious Emotional Disturbance (SED) - Developmental Services Division - Montana was one of ten states awarded the Psychiatric Residential Treatment Facility (Alternatives to PRTF) Demonstration Grant through the Deficit Reduction Act of 2005. CMS approved the five year grant effective October 1, 2007, with the possibility of the grant transforming to a HCBS Waiver at the end of the fifth year. This PRTF Waiver for Youth with SED was available in Yellowstone Carbon, Stillwater, Musselshell, Big Horn, Missoula, Ravalli, Lewis and Clark, Jefferson, Broadwater, Cascade and Flathead counties.

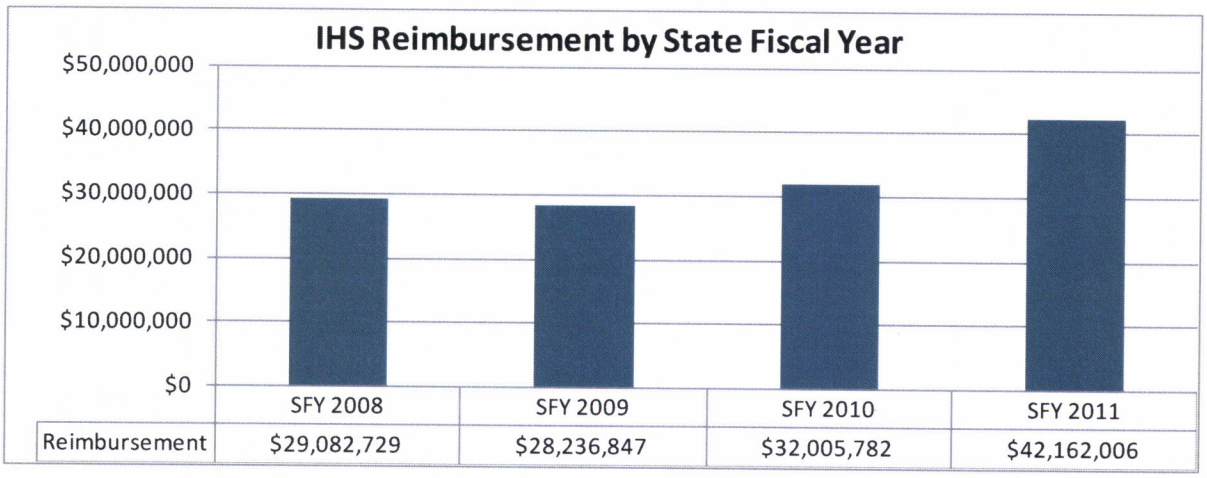
Services included: consultative clinical and therapeutic services; customized goods and services; education and support services; home-based therapist; non-medical transportation; respite care; family support specialist services; caregiver peer-to-peer support specialist services; and wraparound facilitation services. A youth had to be age 6 through 17 and require the level of care of a Psychiatric Residential Treatment Facility to qualify for services. Since the grant began in 2007, through June, 2012, one hundred fifty-two youth were served. The PRTF Demonstration Waiver/Grant ended September 30, 2012, but services will continue through the Bridge Waiver and State Plan.

1915 (c) Bridge Waiver for Youth with Serious Emotional Disturbance (SED) – Developmental Services Division – Implemented October 1, 2012, this waiver is designed to continue to provide services to youth who were enrolled in the PRTF Waiver/Grant on September 30, 2012 until they no longer need the services or became ineligible. No additional youth are allowed to enroll in this waiver. The services are the same as those available through the PRTF Waiver/Grant. It is anticipated that up to 85 youth might be served through this waiver.

Indian Health Service (IHS)

The Montana Medicaid Program provides 100% federal reimbursement for covered medical services to all Medicaid-eligible American Indians who receive those services through an Indian Health Service unit or Tribal health department. By law, the Medicaid program acts as the "pass through" agency for these services. Medicaid reimburses outpatient IHS services on an encounter basis and pays for inpatient services using a per diem payment. Off the reservations, the Indian Health Board of Billings, the Helena Indian Alliance, the Native American Center of Great Falls, the Missoula Indian Center and the North American Indian Alliance of Butte operate and are paid as Federally Qualified Health Care Centers (FQHC) and do not receive 100% federal reimbursement.

Reimbursed medical expenditures to IHS and Tribal health departments.



	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Reimbursement	$29,082,729	$28,236,847	$32,005,782	$42,162,006

Many Native American people are eligible for both IHS and Medicaid services. Other Native American people are only eligible for Medicaid. In either of these circumstances, Medicaid reimburses tribal health departments for care provided with 100% Federal funds. Browning, Crow Agency, and Harlem provide both inpatient and outpatient services. Outpatient-only services are available in Lodge Grass, Poplar, Pryor, Polson, Hays, St. Ignatius, Heart Butte, Lame Deer, Wolf Point, and Arlee.

Tribal Activities

Medicaid Administrative Match (MAM)
MAM is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, tribes with contracts are reimbursed for allowable administrative costs directly related to the Montana State Medicaid

plan or waiver service. The Montana Tribal Cost Allocation Plan gives Tribes a mechanism to seek reimbursement for Medicaid administrative activities that Tribes perform. The program, the first of its kind in the country, began July 1, 2008. Rocky Boy's and Flathead currently have a contract. Crow, Ft. Belknap, & Northern Cheyenne all have contracts under current negotiations.

Chippewa-Cree Agreement
In December 2007, the Department executed an agreement that allows the Chippewa Cree Tribe of the Rocky Boy's Reservation to determine eligibility for Medicaid for residents on the reservation. The agreement reduces barriers/delays that may impede tribal members from obtaining Medicaid benefits and proper medical care. It was renewed in 2010.

Tribal Medicaid Specialist
To help assure that mutual respect and stronger government-to-government relationships are maintained between the Department and American Indian Nations in Montana, a tribal Medicaid Specialist was authorized by the 2005 Legislature. This liaison position assists Tribes to maximize enrollment in and reimbursement by Medicaid. New tribal consultation guidelines have been developed and are being used to oversee proper enrollment of eligible clients in Medicaid, thus opening up better treatment options and services available with the FMAP 100% federal pass-through payment rate. Better use of this pass-through rate saves both state general fund and Indian Health Service dollars.

Master Agreements with all Tribal Governments
The Director's Office successfully negotiated, government-to-government, Master Agreements for all health care dollars passing between the Department of Public Health and Human Services and Montana's tribes. This is a new Department wide contract that covers all boilerplate contract language with tribal governments and DPHHS. It covers reoccurring negotiation issues such as sovereign immunity, insurance, government-to-government respect, court of competent jurisdiction, among others, so these items do not have to be negotiated every time a contract expires. The Master Agreements were signed for a ten (10) year period, with clauses for amendments if agreed upon. With this overarching Master Agreement, all subsequent contracts will now be designated as "task orders" and fall under the Master Agreement with each Tribal government. Some examples of task orders already in place are Medicaid, Pregnant & Parenting Teens, and Tobacco Prevention.

MEDICAID BENEFITS

The Montana Medicaid benefits package meets federal guidelines. Medicaid benefits are divided into two classes. Federal law requires that adults eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers
- Rural Health Clinics
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment

States may elect to cover other optional services. Montana has chosen to cover a number of other cost-effective optional services including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Transportation & Per Diem
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry

There is an exception to a state's ability to decide which optional services it will cover. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** services must be covered under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, it must be made available to all Medicaid eligible individuals under age 21. Under the EPSDT regulations, a state must cover all medically necessary services available under the federal Medicaid program to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen. This is true of whether the service or item is otherwise included in the State Medicaid plan.

The following table outlines services reimbursed by the Montana Medicaid Program:

Montana Medicaid and HMK *Plus* Medicaid Covered Services

The description of services presented here is a guide and not a contract to provide medical care. Administrative rules of Montana, Title 37, Chapters 81 through 88, govern access and payment of services.

	Categorically and Medically Needy: Children and Adults	Family Related Adult Basic
Alcohol, drug treatment: hospital inpatient, outpatient, non-hospital	1	1
Anesthesia	1	1
Audiology	1, 2	3
Case management—targeted	1, 2	1, 2
Chiropractic	5	7
Circumcision	7	7
Clinic: IHS, FQHC, RHC, public health	1	1
Dental, denturist	1	3
Developmental disability	1, 6	1, 6
Dialysis, outpatient and training for self-dialysis	1	1
Durable medical equipment	1, 2	3
EPSDT: Early and Periodic Screening, Diagnosis, and Treatment	5	7
Eye glasses, eye exams, optician	1, 2	3
Family planning services, birth control	1	1
Group home care	5	7
Hearing aids, hearing exams, audiology	1, 2	3
Home, community based, home health	4	7
Home infusion	1	7
Hospital: inpatient, outpatient, emergency department, urgent care, birth center, transitional	1	1
Immunizations	1	1
Interpreter	1	1
Laboratory, imaging, X ray	1	1
Long term care, nursing home, private duty nursing, hospice	1, 6	1, 6
Mental health	1	1
Nurse advice line	1	1
Nutrition counseling	1, 2	1, 2
Obstetric, pregnancy, child birth	1	1
Orthodontia	5	7
Personal assistant	1, 2	7
Pharmacy: prescription and over-the-counter	1, 2	1, 2
Podiatry	1	1
School-based	5	7
Surgery	1	1
Therapies: occupational, physical, speech	1, 2	1, 2
Therapy: respiratory	5	7
Tobacco cessation drugs and counseling	1	1
Transplants	1	1
Transportation, including ambulance for emergency	1, 2	1, 2

1. Covered. **2**. Limits may apply for adults **3**. Usually not covered. Services may be authorized in emergency situations, if essential for employment, or for some medical conditions. **4**. Home and community based services waiver may include coverage for these services for individuals covered by the waiver. **5**. Covered for children only. **6**. Level of care requirements. **7**. Not covered

Enrollment and Expenditures by County SFY 2011

County	County Population 7/1/2011	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
BEAVERHEAD	9,198	757	8%	29	$8,634,638	$11,410	14
BIG HORN	13,093	3,143	24%	3	$24,704,657	$7,860	49
BLAINE	6,565	1,091	17%	7	$10,764,635	$9,863	30
BROADWATER	5,752	405	7%	35	$4,238,161	$10,465	22
CARBON	10,028	602	6%	43	$4,871,690	$8,089	44
CARTER	1,152	48	4%	53	$717,079	$15,070	5
CASCADE	81,837	8,097	10%	22	$86,434,225	$10,675	21
CHOTEAU	5,793	295	5%	49	$3,214,061	$10,898	19
CUSTER	11,752	1,189	10%	20	$12,883,674	$10,836	20
DANIELS	1,763	114	6%	40	$1,571,873	$13,809	9
DAWSON	8,989	565	6%	41	$8,087,929	$14,313	6
DEER LODGE	9,299	1,093	12%	14	$12,202,453	$11,166	16
FALLON	2,956	141	5%	52	$1,592,429	$11,334	15
FERGUS	11,506	944	8%	30	$12,535,980	$13,287	11
FLATHEAD	91,301	9,592	11%	19	$76,956,870	$8,023	46
GALLATIN	91,377	4,460	5%	51	$35,233,905	$7,901	48
GARFIELD	1,251	77	6%	42	$716,203	$9,311	37
GLACIER	13,624	3,397	25%	2	$29,443,220	$8,667	42
GOLDEN VALLEY	865	67	8%	31	$325,349	$4,832	55
GRANITE	3,068	182	6%	44	$2,315,437	$12,699	12
HILL	16,397	2,759	17%	6	$21,464,254	$7,780	50
JEFFERSON	11,381	821	7%	34	$24,397,946	$29,732	1
JUDITH BASIN	2,004	131	7%	39	$1,304,926	$9,999	28
LAKE	28,947	4,511	16%	8	$36,445,597	$8,079	45
LEWIS AND CLARK	64,318	5,528	9%	26	$50,396,259	$9,116	40
LIBERTY	2,402	121	5%	50	$1,228,952	$10,164	26
LINCOLN	19,566	2,461	13%	12	$22,462,590	$9,127	39
MADISON	1,711	361	21%	4	$5,148,849	$14,273	7
MCCONE	7,660	75	1%	56	$710,881	$9,436	34
MEAGHER	1,911	268	14%	11	$1,766,073	$6,598	52
MINERAL	4,208	590	14%	10	$6,131,531	$10,401	24
MISSOULA	110,138	10,007	9%	25	$100,899,867	$10,083	27
MUSSELSHELL	4,701	531	11%	15	$5,521,639	$10,408	23
PARK	15,469	1,137	7%	32	$11,068,952	$9,737	32

Enrollment and Expenditures by County SFY 2011 Continued

County	County Population 7/1/2011	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
PETROLEUM	491	29	6%	45	$100,129	$3,453	56
PHILLIPS	4,250	462	11%	18	$4,516,353	$9,786	31
PONDERA	6,257	916	15%	9	$8,621,630	$9,415	35
POWDER RIVER	1,738	53	3%	55	$1,322,294	$24,754	2
POWELL	7,063	596	8%	27	$8,167,729	$13,698	10
PRAIRIE	1,159	66	6%	46	$1,372,846	$20,774	4
RAVALLI	40,450	4,070	10%	21	$31,455,431	$7,729	51
RICHLAND	10,128	548	5%	47	$5,988,944	$10,929	18
ROOSEVELT	10,527	2,791	27%	1	$25,345,392	$9,081	41
ROSEBUD	9,379	1,580	17%	5	$12,870,270	$8,144	43
SANDERS	11,440	1,266	11%	16	$12,285,392	$9,705	33
SHERIDAN	3,460	242	7%	36	$2,480,134	$10,263	25
SILVER BOW	34,383	4,213	12%	13	$49,854,064	$11,835	13
STILLWATER	9,131	604	7%	37	$4,777,509	$7,916	47
SWEET GRASS	3,623	148	4%	54	$2,098,858	$14,166	8
TETON	6,091	445	7%	33	$4,181,332	$9,394	36
TOOLE	5,239	437	8%	28	$4,878,311	$11,163	17
TREASURE	727	48	7%	38	$291,433	$6,093	54
VALLEY	7,487	826	11%	17	$7,690,047	$9,307	38
WHEATLAND	2,140	199	9%	24	$1,218,259	$6,130	53
WIBAUX	985	53	5%	48	$1,126,349	$21,353	3
YELLOWSTONE	150,069	14,444	10%	23	$144,395,450	$9,997	29
Other / Institution		96	0%		$1,233,408	$12,792	
Sub Total	**998,199**	**99,692**	**10%**		**$962,664,345**	**$9,656**	
QMB Only		4,878			$11,148,530	$2,285	
SLMB - QI Only		2,276			$3,063,858	$1,346	
Grand Total	**998,199**	**106,846**	**11%**		**$976,876,733**	**$9,143**	

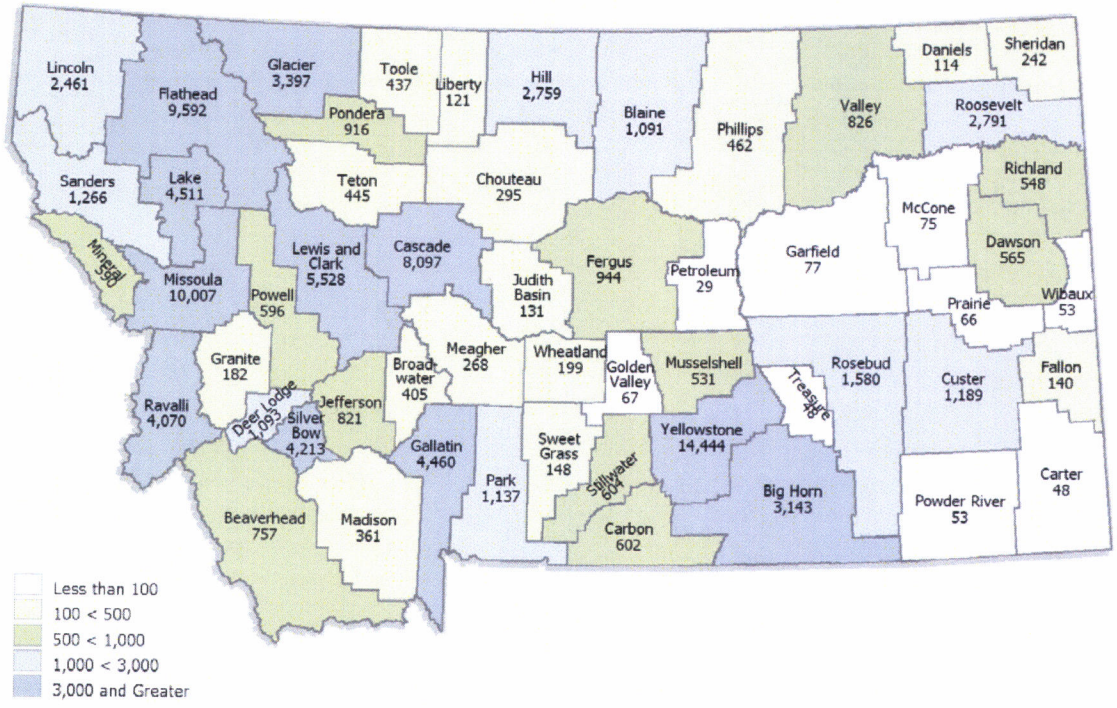
Population estimates as of July 1, 2011 were sourced from the Census & Economic Information Center, Montana Department of Commerce.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums.

The charts on the following pages graphically represent the data presented in the above table.

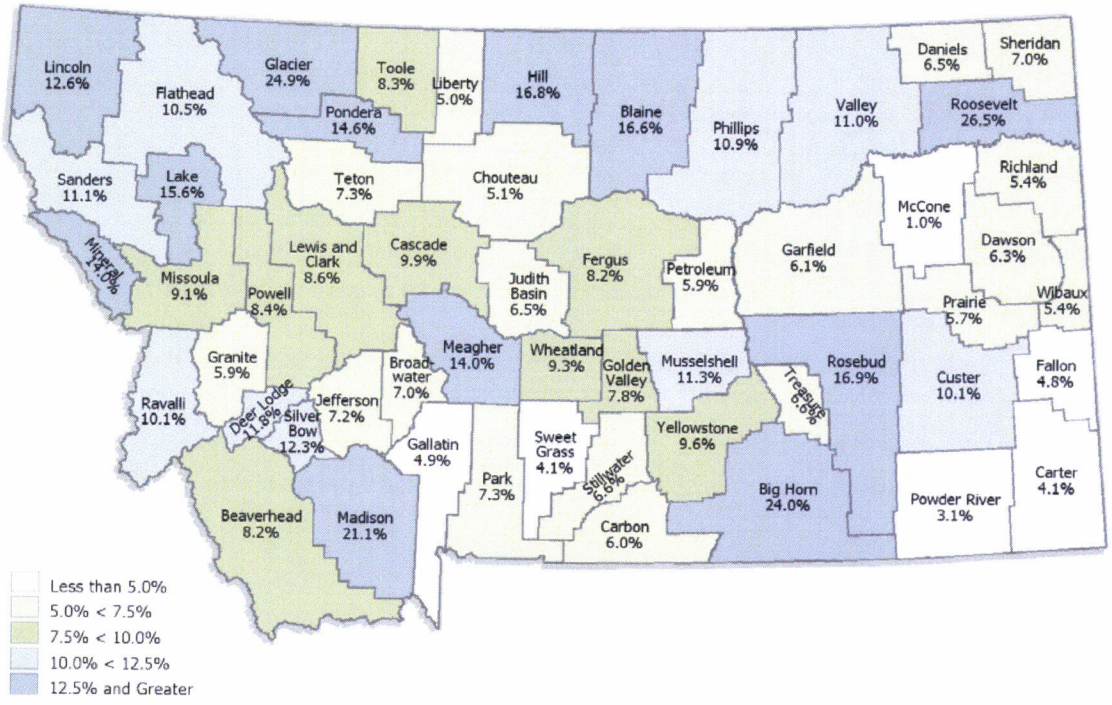
Medicaid Average Monthly Enrollment

State Fiscal Year 2011

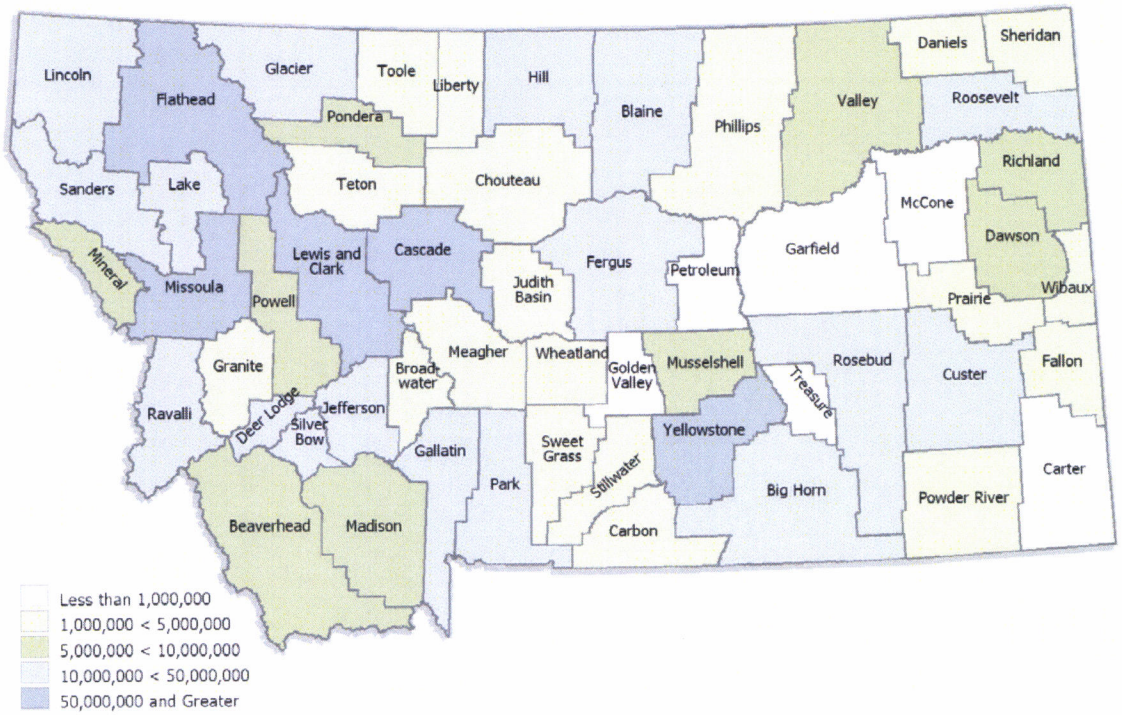


Medicaid Enrollment as Percent of County Population

State Fiscal Year 2011

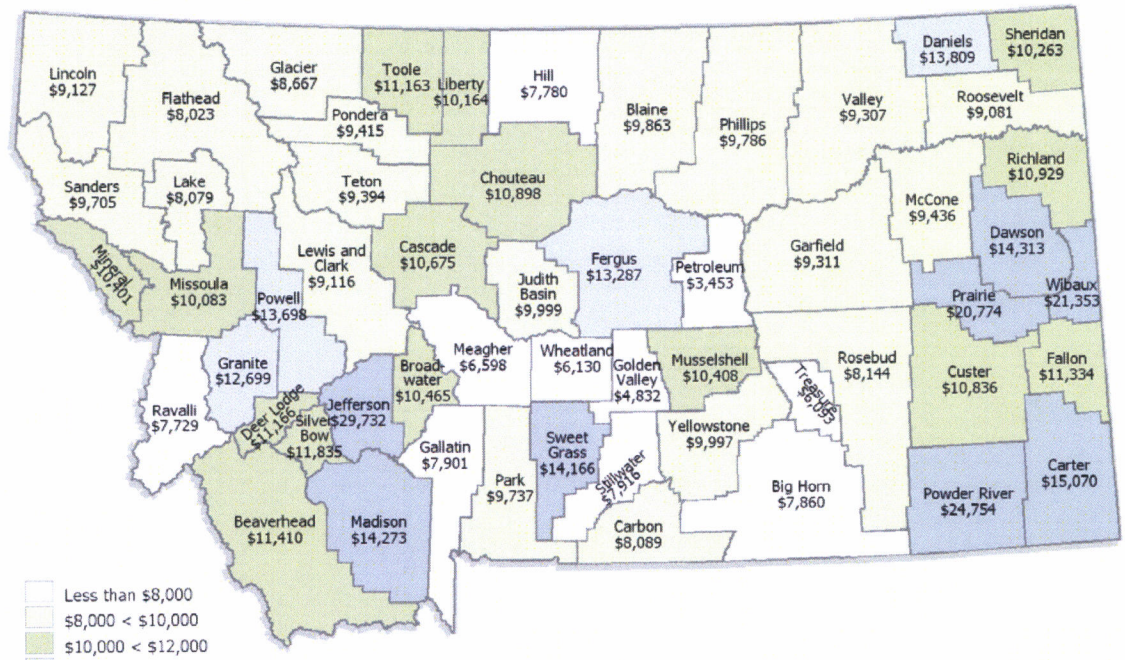


Total Medicaid Expenses
State Fiscal Year 2011

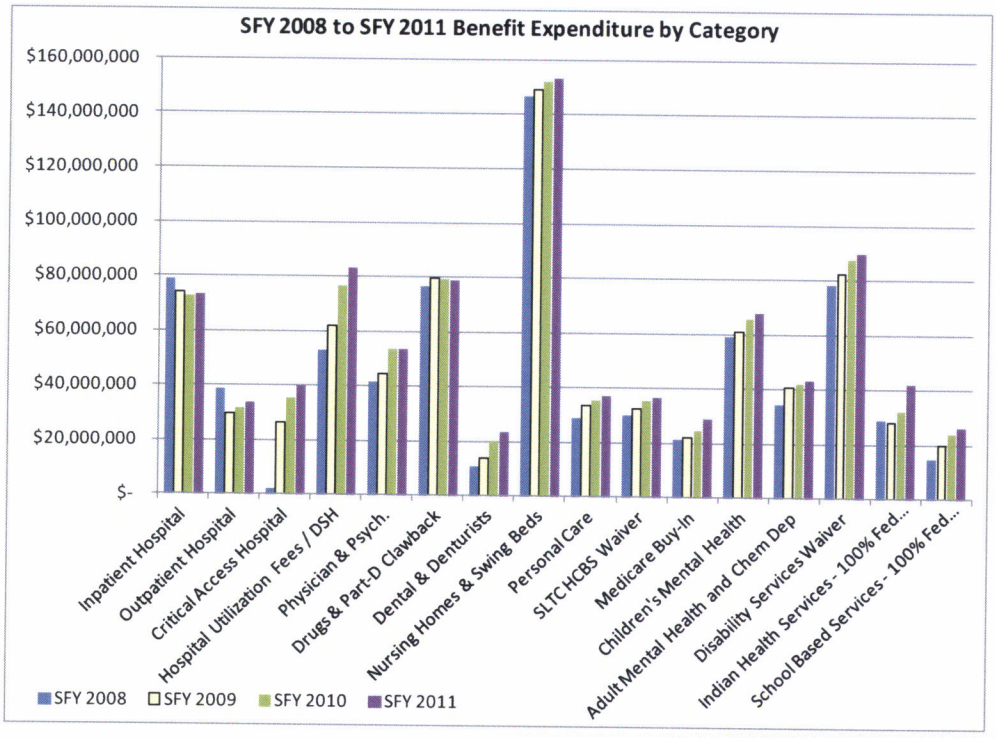


Less than 1,000,000
1,000,000 < 5,000,000
5,000,000 < 10,000,000
10,000,000 < 50,000,000
50,000,000 and Greater

Medicaid Average Expenditure per Enrollee
State Fiscal Year 2011



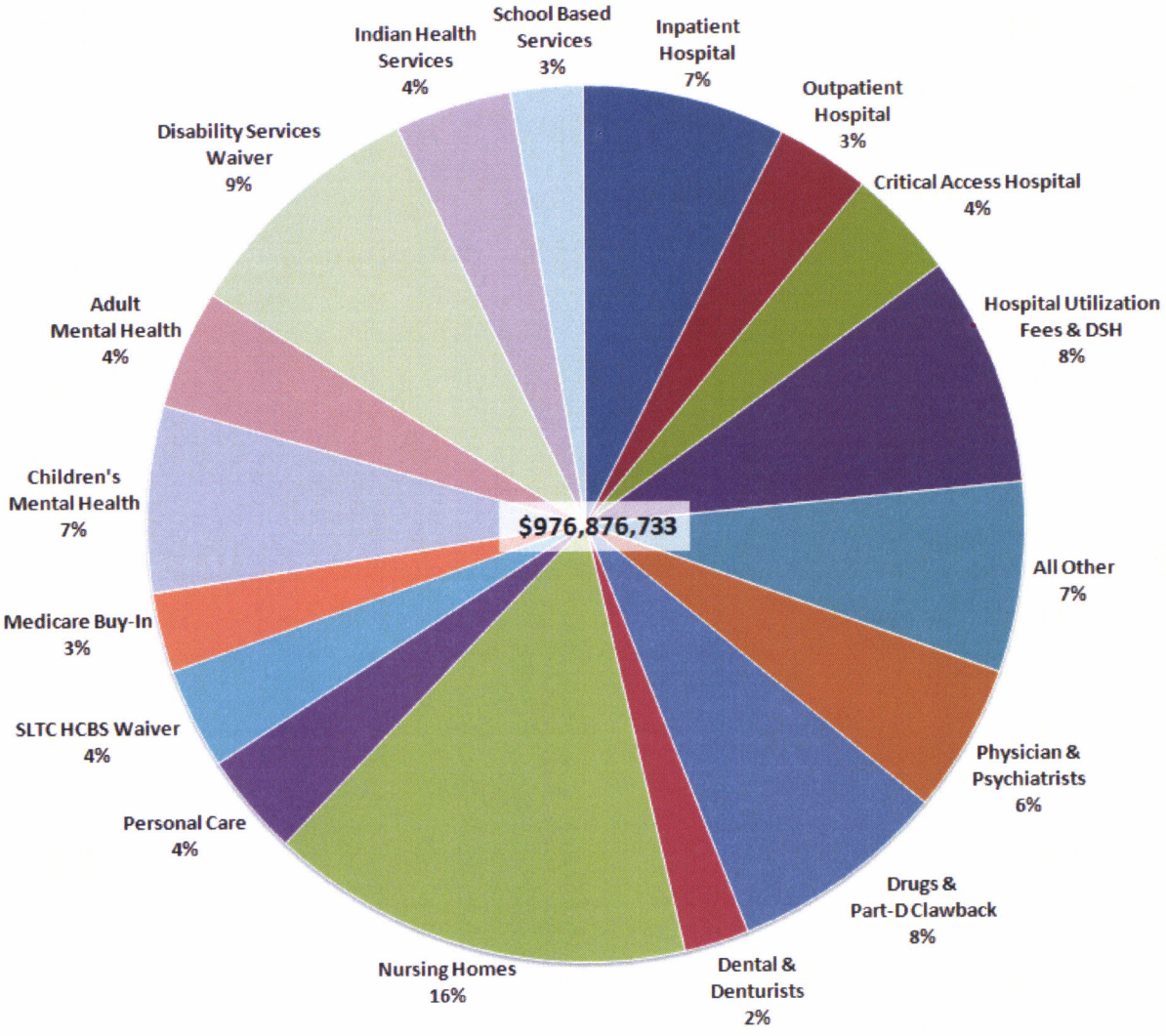
Less than $8,000
$8,000 < $10,000
$10,000 < $12,000
$12,000 < $14,000
$14,000 and Greater



Medicaid Expenditures

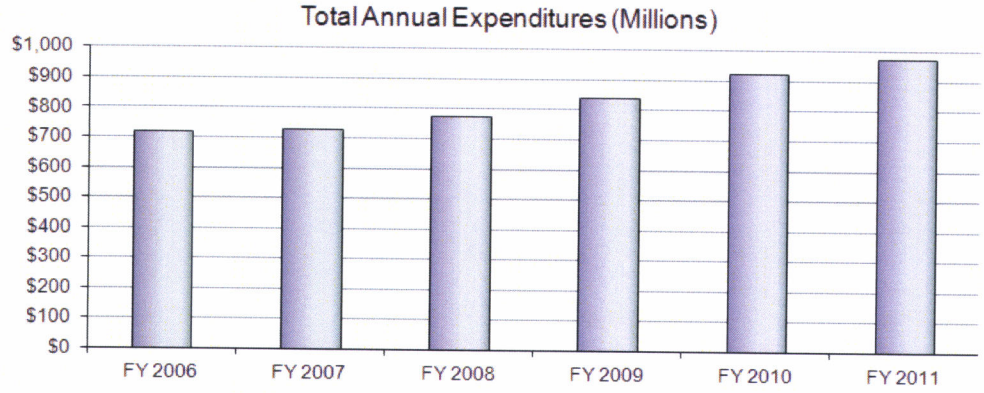
Type	Categories	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Core Medicaid	Inpatient Hospital	$ 78,527,435	$ 73,983,510	$ 72,854,446	$ 73,160,670
Core Medicaid	Outpatient Hospital	38,532,451	29,636,571	31,395,814	33,899,727
Core Medicaid	Critical Access Hospital	1,796,583	26,172,946	35,203,504	39,566,443
Other Medicaid Components	Hospital Utilization Fees / DSH	53,030,319	61,826,736	76,397,030	82,974,552
Core Medicaid	Other Hospital and Clinical Services	12,236,029	13,560,593	16,798,917	20,258,201
Core Medicaid	Physician & Psychiatrists	41,334,868	44,338,755	53,255,184	53,735,237
Core Medicaid	Other Practitioners	11,381,193	13,160,995	15,862,391	17,172,830
Core Medicaid	Other Managed Care Services	3,727,912	6,251,016	6,946,131	8,577,024
Core Medicaid	Drugs & Part-D Clawback	76,709,008	79,206,222	78,979,604	78,572,996
Other Medicaid Components	Drug Rebates	(24,550,872)	(24,150,030)	(27,238,227)	(29,809,486)
Core Medicaid	Dental & Denturists	10,633,173	13,729,107	19,981,116	23,389,974
Core Medicaid	Durable Medical Equipment	11,311,845	11,945,577	12,745,605	13,761,025
Core Medicaid	Other Acute Services	1,940,418	2,567,517	2,771,667	2,669,902
Core Medicaid	Nursing Homes & Swing Beds	146,670,356	148,858,751	152,231,391	152,849,477
Other Medicaid Components	Nursing Home IGT	5,433,517	6,261,101	3,977,854	10,729,944
Core Medicaid	Personal Care	28,668,374	33,597,188	35,183,898	37,112,702
Core Medicaid	Other SLTC Home Based Services	2,956,910	5,152,118	11,095,179	11,529,298
Waiver	SLTC HCBS Waiver	29,687,859	32,181,787	35,512,520	36,502,376
Other Medicaid Components	Medicare Buy-In	21,385,058	21,947,428	24,636,881	28,579,323
Core Medicaid	Children's Mental Health	58,894,797	60,793,197	65,661,684	67,441,463
Core Medicaid	Adult Mental Health and Chem Dep	34,510,868	40,451,536	41,701,001	42,962,700
Waiver	HIFA Waiver	-	-	75	966,660
Waiver	Disability Services Waiver	77,848,992	82,026,211	87,163,567	89,439,291
Federal Only	Indian Health Services - 100% Fed funds	29,082,729	28,236,847	32,005,782	42,162,006
Federal Only	School Based Services - 100% Fed funds	14,510,813	20,040,617	23,873,511	25,981,721
Federal Only	MDC & ICF Facilities - 100% Fed funds	12,395,498	13,147,003	15,097,759	12,690,679
Total	Total	$ 778,656,133	$ 844,923,298	$ 924,094,285	$ 976,876,733

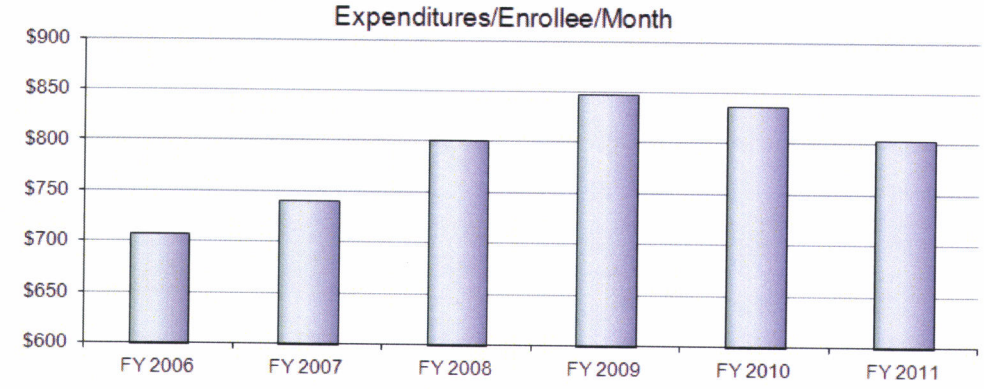
State Fiscal Year 2011 Medicaid Benefit Expenditures

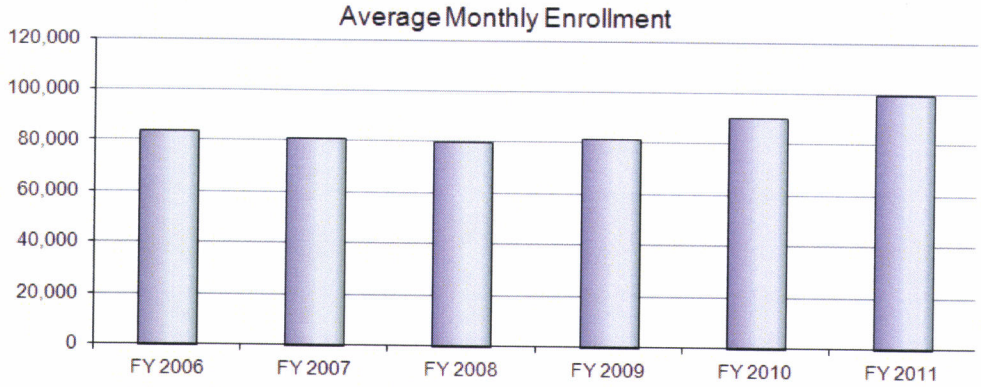


The charts and tables below show the average per-member per-month reimbursement for various age groups and Medicaid eligibility categories. This calculation has changed from prior versions by merging claims and eligibility data. While eligibility is updated over time, once a claim is processed, the information on the claim is static. The new methodology ensures a client's enrollment and reimbursement are counted in the same category and the updated enrollment information takes precedence over the claim information.

History of Expenditures and Enrollment







Enrollment and expenditures exclude administrative costs, Medicare Savings Plan, HMK (CHIP) and State Funded Mental Health. Decline in per-member reimbursement is attributable to increased enrollment of low cost children.

Medicaid Average Enrollment per Month

		State Fiscal Year					
Age	**Category**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
< 1	Blind/Disabled	73	76	79	69	75	70
< 1	Child	5,119	5,333	5,298	5,372	5,642	5,851
1 to 5	Blind/Disabled	524	566	615	627	655	629
1 to 5	Child	16,211	15,861	15,813	16,481	19,356	22,164
6 to 18	Blind/Disabled	1,981	2,097	2,203	2,283	2,320	2,392
6 to 18	Child	24,416	23,320	22,676	23,130	26,969	31,585
19 to 20	Blind/Disabled	460	494	491	500	530	524
19 to 20	Adult	1,302	1,166	1,119	1,192	1,288	1,226
21 to 64	Blind/Disabled	14,207	14,164	14,426	14,913	15,346	15,779
21 to 64	Adult	12,412	11,276	10,362	10,253	11,485	12,349
65 +	Aged	6,552	6,148	6,085	6,127	6,473	6,966
65 +	Blind/Disabled	724	732	751	754	526	157
Total		**83,982**	**81,232**	**79,918**	**81,699**	**90,666**	**99,692**
All	QMB	3,012	3,803	4,026	4,209	4,509	4,878
All	SLMB - QI	1,513	1,768	1,804	1,898	2,019	2,276
Total	**All Medicaid**	**88,507**	**86,804**	**85,748**	**87,807**	**97,193**	**106,846**
6 to 18	HK Med Plus					2,071	5,568
Total	**All Categories**	**88,507**	**86,804**	**85,748**	**87,807**	**99,265**	**112,414**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP.

Medicaid Per Member Per Month Reimbursement

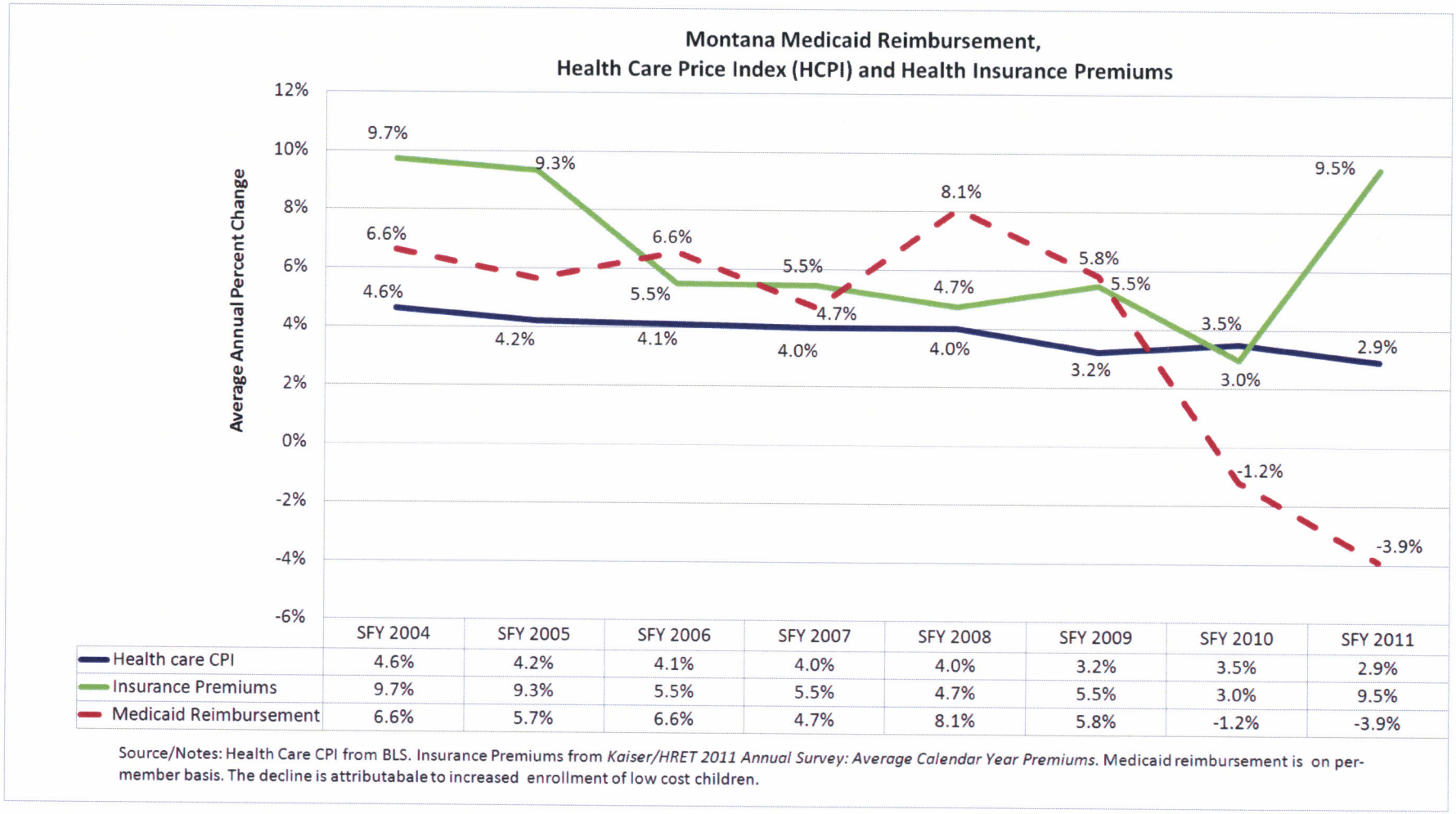
		State Fiscal Year					
Age	**Category**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
< 1	Blind/Disabled	$3,925	$4,109	$4,127	$3,365	$5,311	$3,660
< 1	Child	$606	$646	$728	$730	$657	$721
1 to 5	Blind/Disabled	$1,563	$1,385	$1,360	$1,559	$1,689	$1,772
1 to 5	Child	$125	$133	$134	$147	$165	$165
6 to 18	Blind/Disabled	$1,584	$1,701	$1,848	$1,818	$1,887	$1,867
6 to 18	Child	$308	$310	$317	$348	$351	$334
19 to 20	Blind/Disabled	$1,223	$1,291	$1,463	$1,557	$1,364	$1,584
19 to 20	Adult	$532	$580	$647	$693	$708	$753
21 to 64	Blind/Disabled	$1,456	$1,490	$1,583	$1,714	$1,817	$1,822
21 to 64	Adult	$452	$501	$563	$608	$625	$642
65 +	Aged	$2,164	$2,265	$2,410	$2,496	$2,510	$2,483
65 +	Blind/Disabled	$1,169	$1,129	$1,172	$1,245	$1,368	$1,349
Total		**$708**	**$742**	**$802**	**$849**	**$837**	**$805**
All	QMB	$148	$157	$163	$202	$195	$190
All	SLMB - QI	$83	$92	$95	$95	$102	$112
Total	**All Medicaid**	**$679**	**$703**	**$757**	**$802**	**$792**	**$762**
6 to 18	HK Med Plus					$247	$215
Total	**All Categories**	**$679**	**$703**	**$757**	**$802**	**$780**	**$735**

For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP.

Medicaid Reimbursement

		State Fiscal Year					
Age	**Category**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
< 1	Blind/Disabled	$3,418,749	$3,755,647	$3,929,114	$2,776,021	$4,764,152	$3,077,670
< 1	Child	$37,196,866	$41,316,032	$46,289,296	$47,069,359	$44,505,460	$50,605,506
1 to 5	Blind/Disabled	$9,833,646	$9,400,774	$10,032,088	$11,735,169	$13,263,824	$13,386,244
1 to 5	Child	$24,359,989	$25,290,336	$25,498,959	$29,091,321	$38,356,966	$43,971,517
6 to 18	Blind/Disabled	$37,654,024	$42,821,899	$48,852,535	$49,803,355	$52,547,395	$53,606,189
6 to 18	Child	$90,292,300	$86,852,385	$86,310,116	$96,576,858	$113,685,847	$126,673,567
19 to 20	Blind/Disabled	$6,745,333	$7,654,767	$8,626,193	$9,342,218	$8,677,203	$9,965,080
19 to 20	Adult	$8,314,219	$8,115,353	$8,685,900	$9,912,441	$10,946,130	$11,078,043
21 to 64	Blind/Disabled	$248,226,383	$253,220,533	$274,054,166	$306,677,871	$334,676,224	$345,051,465
21 to 64	Adult	$67,390,119	$67,733,279	$69,960,964	$74,768,281	$86,074,810	$95,142,865
65 +	Aged	$170,187,983	$167,097,127	$175,941,015	$183,529,425	$194,940,298	$207,568,377
65 +	Blind/Disabled	$10,157,479	$9,908,134	$10,563,969	$11,269,779	$8,628,672	$2,537,822
Total		**$713,777,088**	**$723,166,268**	**$768,744,316**	**$832,552,100**	**$911,066,981**	**$962,664,345**
All	QMB	$5,363,569	$7,181,004	$7,863,762	$10,217,915	$10,554,609	$11,148,530
All	SLMB - QI	$1,514,827	$1,944,858	$2,048,056	$2,153,283	$2,472,695	$3,063,858
Total	**All Medicaid**	**$720,655,483**	**$732,292,129**	**$778,656,133**	**$844,923,298**	**$924,094,285**	**$976,876,733**
6 to 18	HK Med Plus					$4,606,582	$14,378,807
Total	**All Categories**	**$720,655,483**	**$732,292,129**	**$778,656,133**	**$844,923,298**	**$928,700,866**	**$991,255,541**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP.



	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Health care CPI	4.6%	4.2%	4.1%	4.0%	4.0%	3.2%	3.5%	2.9%
Insurance Premiums	9.7%	9.3%	5.5%	5.5%	4.7%	5.5%	3.0%	9.5%
Medicaid Reimbursement	6.6%	5.7%	6.6%	4.7%	8.1%	5.8%	-1.2%	-3.9%

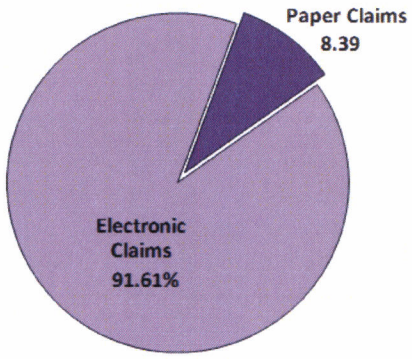
Source/Notes: Health Care CPI from BLS. Insurance Premiums from *Kaiser/HRET 2011 Annual Survey: Average Calendar Year Premiums*. Medicaid reimbursement is on per-member basis. The decline is attributabale to increased enrollment of low cost children.

PROVIDERS AND CLAIMS PROCESSING

Medicaid provides services through a network of private and public providers. The Department contracts with XEROX to process claims for reimbursement. XEROX meets the rigorous requirements established by the Centers for Medicare and Medicaid Services to be a Medicaid fiscal agent. XEROX processed over 7.49 million claims in SFY 2012 and 14,918 providers were enrolled as Montana Medicaid providers as of June 30, 2012.

Below are the statistics on the number of claims submitted and processed in SFY 2012.

Claim Type	*Number Processed*	*% of Total*
Paper Claims	628,249	8.3%
Electronic Claims	6,862,073	91.61%
Total Claims	7,490,322	100%



RATE SETTING PROCESS

The Montana Medicaid Program uses several methods to establish payment rates for services. The methodology used for reimbursement varies from service to service.

Reimbursement Systems for Hospitals

Montana Medicaid's reimbursement systems include an All Patient Diagnosis Related Groups (DRG) system for inpatient services for some hospitals, Ambulatory Payment Classification (APC) for these same hospitals for outpatient hospital services, and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates. Critical access hospitals receive cost-based reimbursement. This reimbursement system was adopted to help ensure access in Montana's small communities.

Resource Based Relative Value System (RBRVS)

Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with Medicare's resource based relative value system (RBRVS). Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units (RVU's) designating its position on the relative value scale. This system was developed nationally by Centers for Medicare & Medicaid Services (CMS), the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation and utilization.

Price-Based Reimbursement System

Nursing facilities are reimbursed under a case mix, price-based system where rates are determined annually, effective July 1. Each nursing facility receives a facility specific rate. The statewide price for nursing facility services is established annually through a public process. Each nursing facility's payment is comprised of two components, the operating component, including capital, and the direct resident care component. Each nursing facility receives the same operating per diem rate, which is 80% of the statewide price. The remaining 20% of the rate represents the direct resident care component of the rate. Each facility's direct resident care component rate is specific to the facility based on the acuity of the Medicaid residents served in the facility, as measured by the minimum data set.

Fee-for-Service

Fee-for-service simply means that a fee is established for a certain product or service. Pharmacy services are one of the major services reimbursed under the fee for service methodology. Pharmacies receive both a dispensing fee for each prescription plus the cost of the ingredient. Ingredient costs are reimbursed at the estimated acquisition cost for each product.

Medicaid uses the Medicare fee-for-service rates and per encounter payment systems for some programs. This allows efficient maintenance and the use of already established fee schedules for certain areas. Some examples of programs that use Medicare fee schedules include Durable Medical Equipment, Ambulatory Surgical Centers, and Federally Qualified Health Clinics.

COST CONTAINMENT MEASURES

The Medicaid program continues to develop cost containment measures that enhance the cost effectiveness and efficiency of the program. Some examples include:

School Based Services:

- Services formerly paid with state or local funds only are now matched with federal funds in the Medicaid program. This has allowed children to receive additional needed services such as mental health care and speech therapy at no additional cost to the school district. The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services written into the Children's Individualized Education Plans.

Health Resources Cost Containment Measures:

- Nurse Advice Line - Toll free, confidential advice line available to all people with Medicaid. Registered nurses triage caller's symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care).

- Team Care - Medicaid clients with a history of using Medicaid services at an amount or frequency that is not medically necessary are required to participate in order to control utilization. Team Care clients are managed by a team consisting of a PASSPORT primary care provider, one pharmacy, the Nurse Advice Line, and DPHHS staff. Team Care currently has 600 clients.

- PASSPORT to Health - Primary Case Management Program was implemented in 1993 to cost-avoid medical costs and improve quality of care. A client chooses one primary care provider who performs or provides referrals for almost all of the client's care. Periodic surveys show that more than 80% of both providers and clients are satisfied with PASSPORT to Health.

- Out-of-State Inpatient & Outpatient Hospital - Prior authorization (mandatory advance approval) for all inpatient hospital services out-of-state. This prior authorization encourages the utilization of available health resources in-state.

- Prior authorization and assistance with obtaining certain transportation services.

- Bulk purchase of eyeglass services.

Pharmacy:

- Prior Authorization - Mandatory advance approval of certain drugs before they are dispensed for any medically accepted indication.

- Drug Utilization Review - Prospective and retrospective review of drug use.

- Over-the-Counter Drug Coverage - When prescribed by a physician, over the counter drugs are paid for as a cost effective alternative to higher priced federal legend drugs.

- Mandatory Generic Substitution - Requires pharmacies to dispense the generic form of the drug.

- Other Permissible Restrictions - Minimum or maximum quantities per prescription or number of refills.

- Preferred Drug List and Supplemental Rebates - Medicaid's Drug Utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered to the Medicaid program.

- Drug Rebate Collection - The Department has two full time staff dedicated to the rebate program and the use of the Drug Rebate Analysis and Management System (DRAMS). The staff conducts claims audits and invoice audits prior to invoicing pharmaceutical manufacturers. These staff procedures assure more accurate invoices being sent to the manufacturers and eliminate or reduce disputes with the manufacturers. This results in more timely payments being received from the manufacturers. Drug rebates averaged approximately 30% of the Medicaid pharmacy expenditures. This percentage rate is higher than the past years and is related to Part D and the Average Manufacture Pricing (AMP) calculation. This percentage will be lower as the AMP rates are now being readjusted at the federal level for future fiscal years. The Department has also contracted with XEROX to collect rebates on selected physician administered drugs.

Senior and Long Term Care Cost Containment Measures:

- Long term care insurance partnerships were added to the insurance options that are available in Montana for consumers. Purchase of insurance will help defray Medicaid costs in the future as partnership policies are utilized. An institutionalized/waiver individual or spouse who purchased a Qualified Long Term Care Partnership (LTC) policy or converted a previously-existing LTC policy to a Qualified LTC Partnership policy on or after July 1, 2009 may protect resources equal to the insurance benefits received from the policy.

  Asset protection through LTC Partnership is available only after Qualified LTC Partnership policy lifetime limits have been fully exhausted on LTC services for the Medicaid applicant or spouse. The amount of assets protected will be equal to the insurance benefits paid

- Prior authorization for personal assistance services

- Intergovernmental fund transfer for counties to provide additional payments to at risk nursing facilities.

- Effective July 1, 2001 a new price based reimbursement methodology was adopted for reimbursement of nursing facilities in the state and continues to this day to provide for predictability in reimbursement for these providers.

- Nursing facility transitions have been used as a vehicle to provide services in the least restrictive setting to consumers who move from the nursing facility into community services; with dollars for services following them from the nursing facility budget in a money follows the person approach to rebalancing the long term care system. Typically individuals can be served in the community at a lower cost than in the institution. This approach has been in existence since 2004 and since that time over 250 individuals have transitioned to community placements using this approach.

- Other options such as Money Follows the Person grant funding and Community First Choice Option, a personal assistance state plan option, are being considered to further the Division's efforts at rebalancing long term care services and supports toward increased use of home and community based care and decreased use of intuitional care. Enhanced federal funding is available under both options.

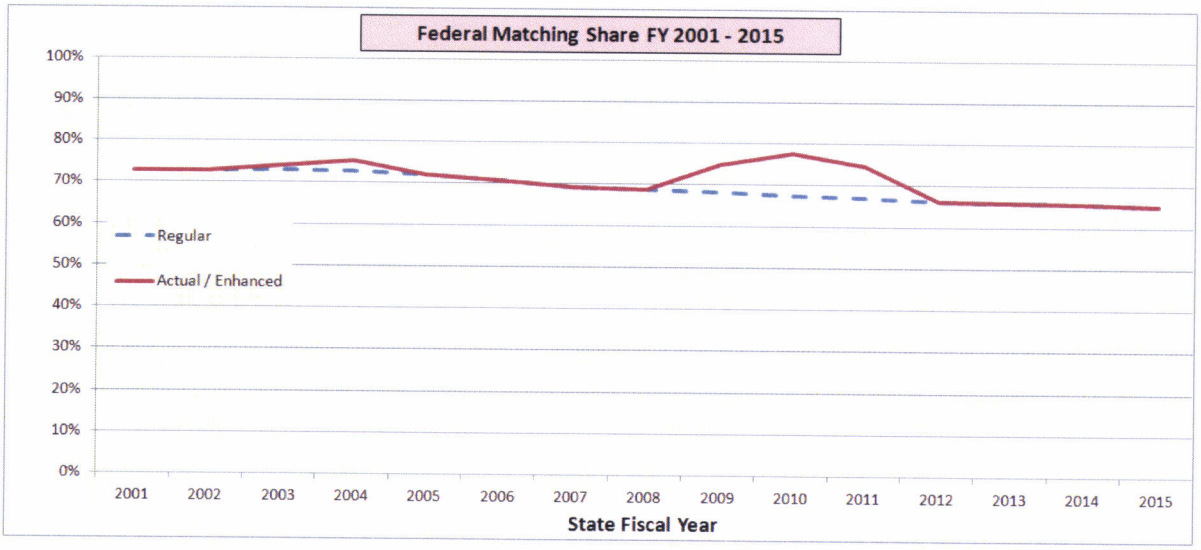
EXPENDITURE ANALYSIS

Medicaid services are funded by a combination of federal and state (and in some situations local) funds. The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average. For example, in Fiscal Year 2006 for every Medicaid dollar, the federal share was 70.66 cents and the Montana state share was 29.34 cents. In Fiscal Year 2012, the Federal share was 66.21 cents and the State share was 33.79 cents.

Montana Medicaid Benefits Federal Matching

State Fiscal Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Federal Match Rate	70.66%	69.29%	68.59%	74.80%	77.65%	74.58%	66.21%	65.99%	65.62%	65.20%
State Match Rate	29.34%	30.71%	31.41%	25.20%	22.35%	25.42%	33.79%	34.01%	34.38%	34.80%

The following chart illustrates the increase in the federal share of Medicaid costs that were made available by the federal government during past economic downturns. The increase in federal match for FY2003-04 was implemented as a result of the Jobs and Growth Tax relief Reconciliation Act of 2003. Federal match was increased in FY2008-11 due to the enactment of the American Recovery and Reinvestment Act.

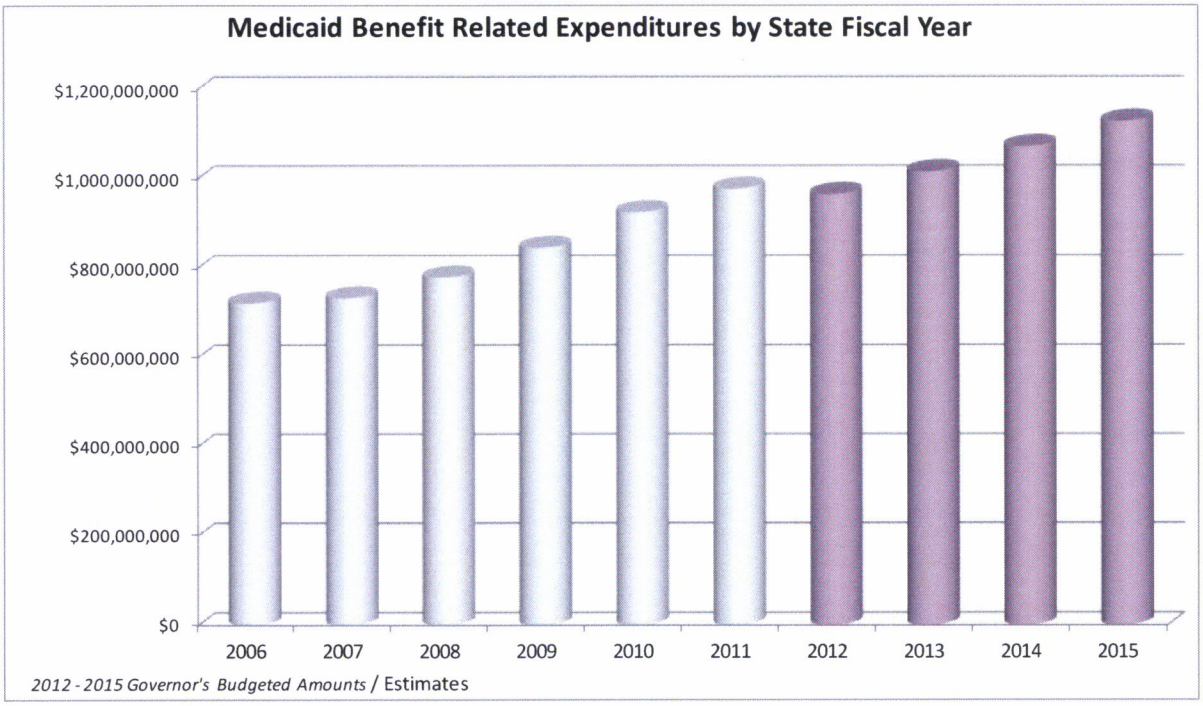


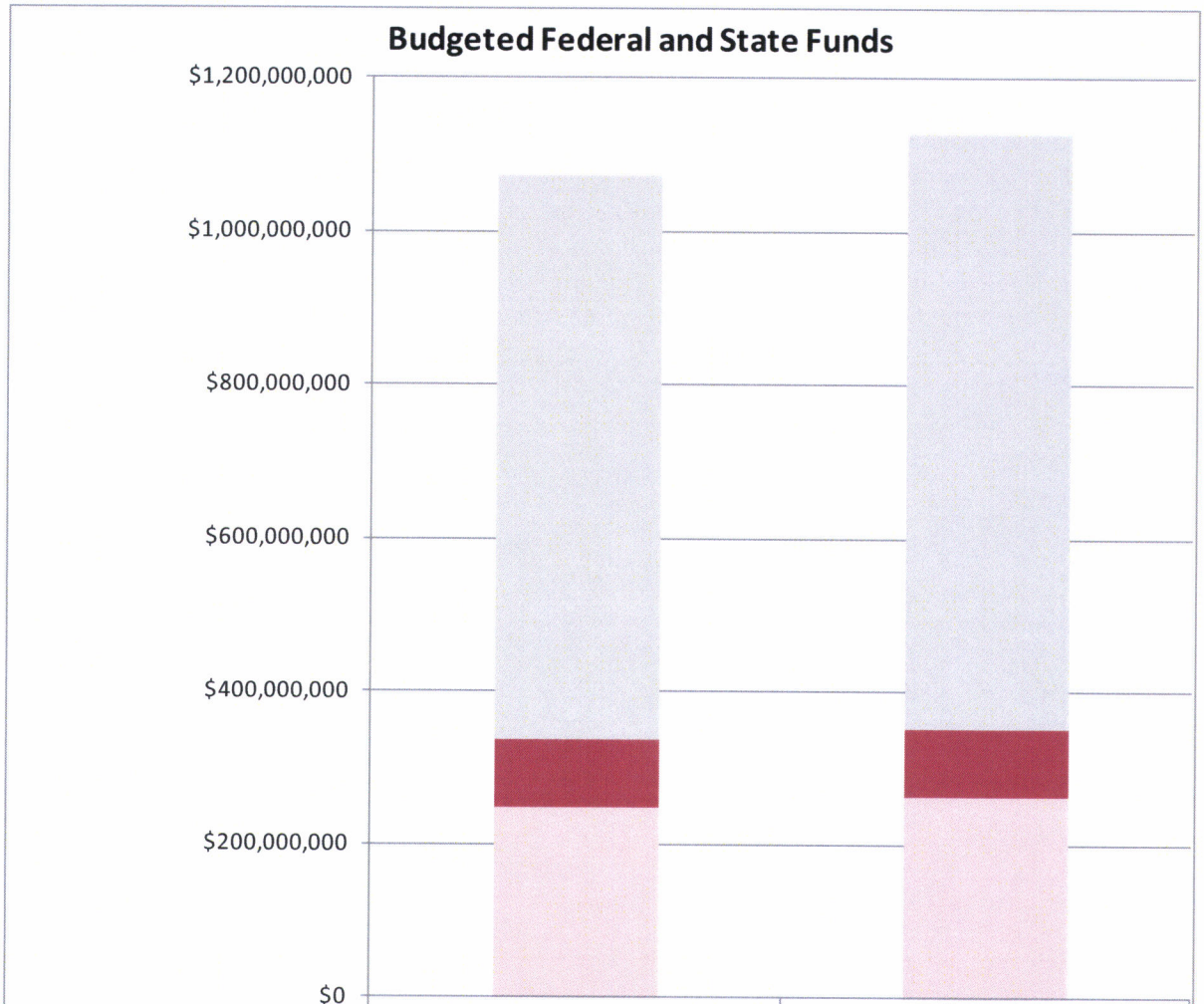
State Fiscal Year	2001	2002	2003	2004	2005	2006	2007	2008
Regular	72.85%	72.88%	72.96%	72.81%	71.96%	70.66%	69.29%	68.59%
Actual / Enhanced	72.85%	72.88%	74.15%	75.36%	71.96%	70.66%	69.29%	68.59%

State Fiscal Year	2009	2010	2011	2012	2013	2014	2015	
Regular	68.08%	67.48%	66.86%	66.21%	65.99%	65.62%	65.20%	
Actual / Enhanced	74.80%	77.65%	74.58%	66.21%	65.99%	65.62%	65.20%	

Montana Medicaid Benefits Related Expenditures

The following series of Medicaid expenditure data only includes benefit related expenditures. It does not include administrative activity costs. Benefit related expenditures for Hospital Utilization Fee distributions, Medicaid Buy-in, Intergovernmental Transfers (IGT), Pharmacy Rebates, Part-D Pharmacy Clawback, Institutional Reimbursements for Medicaid, Third Party Liability (TPL), and Medically Needy offsets are included. These are non-audited expenditures on a date of service basis. Unless otherwise noted all reimbursement and eligibility data in the report was collected from the month end reports on September 2012. Data for state fiscal years 2012 to 2015 are the Governor's budgeted amounts and/or estimates. The Governor's projected budget for FY 14 and FY 15 also includes proposed provider rate increases.





	FY 2014	FY 2015
Federal Fund	$734,899,758	$774,999,035
State Special Revenue	$89,596,129	$91,091,470
State General Fund	$246,554,297	$261,657,517
Total Budgeted Expenditures	$1,071,050,184	$1,127,748,022

To better understand how Medicaid costs are driven, and identify significant factors affecting growth, reimbursement has been grouped into four types.

- Core Medicaid consists of reimbursement for medical services. Major categories that are included in Core Medicaid are Inpatient Hospital, Nursing Homes, and Physicians.
- Other Medicaid Components consists of Medicaid reimbursement that is made in addition to medical services, but cannot be matched to a specific client service. Major categories of this type are Nursing Home IGT, Drug Rebate, Clawback and Hospital Utilization Fees / DSH.
- Waiver consists of waiver services reimbursed by Medicaid. These services are made up of the DD Services Waiver, Home and Community Based Services Waivers (PT 28), and HIFA Waiver.
- Federal Only consists of services where the DPHHS state share for the service is zero. For these services the federal share is either 100% of the service or, as in the case of CSCT services, another entity other than DPHHS pays the state share. Major categories in this type include Indian Health Services and School Services.

We have made these distinctions because the Department has different goals for expenditures in each of these areas. As an example, we are very aggressive in pursuing "other Medicaid components" and "Federal only" because these two categories decrease the state funding that would otherwise be needed. The "waiver" category reflects increases in legislative appropriation for community-based services offered as an alternative to facility-based care. "Core" Medicaid most closely equates to services paid for by other insurers.

Medicaid Expenditures

Type	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Core Medicaid	$548,226,761	$588,395,670	$624,527,537	$651,140,991
Other Medicaid Components	$66,107,041	$79,030,336	$103,350,684	$115,112,053
Waiver	$108,333,291	$116,072,825	$125,239,011	$129,789,284
Federal Only	$55,989,040	$61,424,467	$70,977,052	$80,834,406
Total	$778,656,133	$844,923,298	$924,094,285	$976,876,733

Percent Change from Previous Year

	SFY 2009	SFY 2010	SFY 2011
Core Medicaid	7.33%	6.14%	4.26%
Other Medicaid Components	19.55%	30.77%	11.38%
Waiver	7.14%	7.90%	3.63%
Federal Only	9.71%	15.55%	13.89%
Total	8.51%	9.37%	5.71%

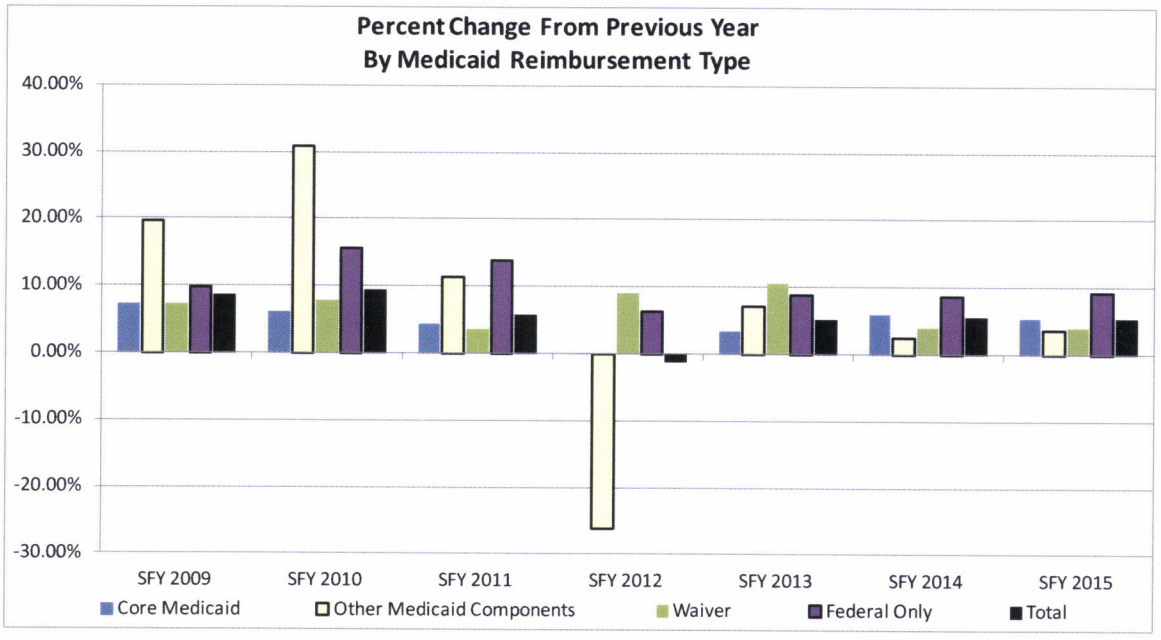
The top half of the chart above shows the historical expenditures for each reimbursement type from FY 2008 to FY 2011. The bottom of the chart shows the percent change by reimbursement type from the previous year. For example, Waiver type reimbursement in FY 2010 increased by 7.90% over FY 2009. This was a reflection of both increased slots and provider rate increases.

The table on the following page shows the same information for projected Medicaid expenditures in FY 2012 and the Governor's budget for FY 2014 to FY 2015.

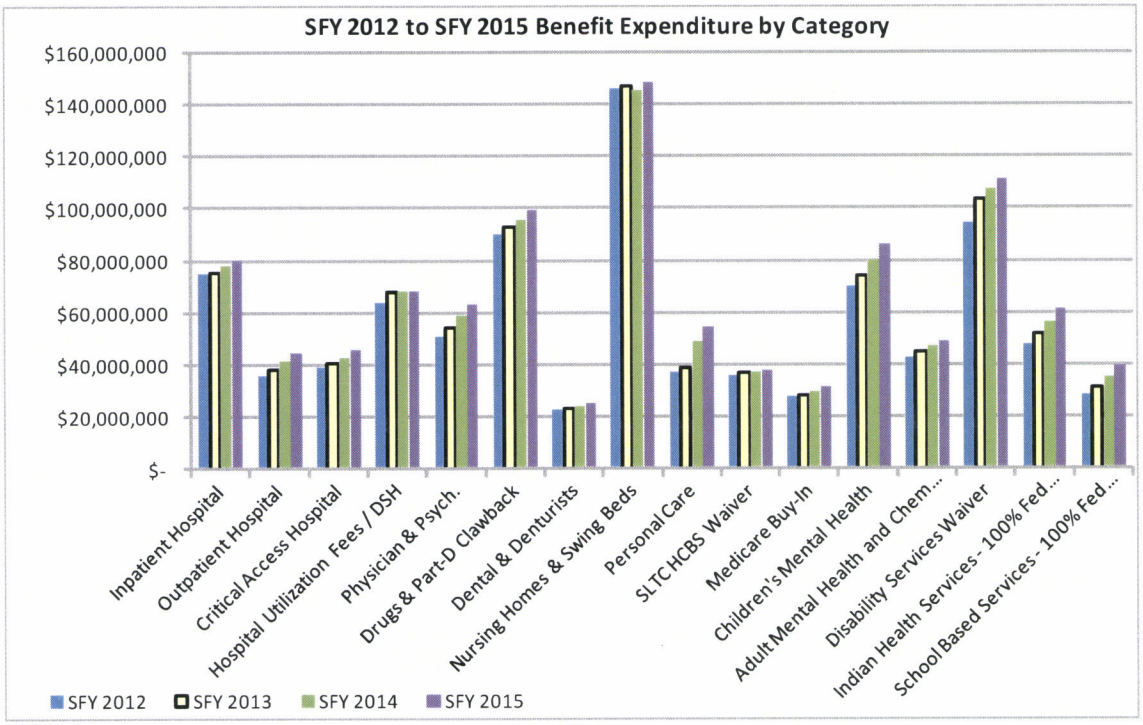
	Medicaid Expenditures (Projected / Gov's Budget)			
Type	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Core Medicaid	$652,242,164	$673,900,186	$713,614,792	$750,974,353
Other Medicaid Components	$85,106,394	$91,072,970	$93,287,060	$96,696,998
Waiver	$141,471,330	$156,456,883	$162,655,548	$169,202,882
Federal Only	$85,924,433	$93,498,684	$101,492,784	$110,873,789
Total	$964,744,321	$1,014,928,723	$1,071,050,184	$1,127,748,022

	Percent Change from Previous Year			
	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Core Medicaid	0.17%	3.32%	5.89%	5.24%
Other Medicaid Components	-26.07%	7.01%	2.43%	3.66%
Waiver	9.00%	10.59%	3.96%	4.03%
Federal Only	6.30%	8.82%	8.55%	9.24%
Total	-1.24%	5.20%	5.53%	5.29%

SFY 14 and 15 include proposed provider rate increases. The large drop in Other Medicaid Components in SFY 2012 is due to increased drug rebates and a decrease in Hospital Utilization Fees. Hospital Utilization Fees decreased due to the enhanced FMAP in SFY 2011 reverting to Regular FMAP in SFY 2012.



The above chart above illustrates the percent change from the previous year for each reimbursement type. For FY 2013 to FY 2015 these are the projected budget amounts. The graph shows that projected growth in FY 2014 and FY 2015 is lower than actual growth in FY 2009 to FY 2011 because we believe that the economy is improving. The projected amounts are broken out in more detail on the following page.



		Medicaid Expenditures (Projected / Gov's Budget)			
Type	Categories	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Core Medicaid	Inpatient Hospital	$ 74,900,673	$ 75,649,680	$ 77,904,190	$ 80,266,266
Core Medicaid	Outpatient Hospital	36,113,097	38,391,864	41,536,683	44,834,371
Core Medicaid	Critical Access Hospital	38,934,574	40,564,395	43,041,133	45,588,952
Other Medicaid Components	Hospital Utilization Fees / DSH	63,996,224	68,157,471	68,183,527	68,210,037
Core Medicaid	Other Hospital and Clinical Services	20,701,390	22,106,589	23,949,985	25,870,137
Core Medicaid	Physician & Psychiatrists	51,073,114	54,229,179	58,620,083	63,206,838
Core Medicaid	Other Practitioners	16,796,018	18,002,975	19,623,984	21,371,373
Core Medicaid	Other Managed Care Services	8,636,781	8,820,153	9,029,656	9,246,964
Core Medicaid	Drugs & Part-D Clawback	90,214,026	92,645,659	95,823,465	99,554,699
Other Medicaid Components	Drug Rebates	(48,090,298)	(48,428,547)	(50,103,449)	(51,140,979)
Core Medicaid	Dental & Denturists	22,786,858	23,383,416	24,359,649	25,343,060
Core Medicaid	Durable Medical Equipment	13,937,422	14,473,615	15,175,173	15,910,737
Core Medicaid	Other Acute Services	2,534,113	2,673,341	2,847,377	3,033,190
Core Medicaid	Nursing Homes & Swing Beds	145,831,816	146,535,418	145,441,654	148,307,108
Other Medicaid Components	Nursing Home IGT	16,099,081	16,099,081	22,651,002	23,945,170
Core Medicaid	Personal Care	36,863,365	39,005,847	48,705,836	54,600,477
Core Medicaid	Other SLTC Home Based Services	9,414,053	10,428,398	9,952,418	10,537,327
Waiver	SLTC HCBS Waiver	36,014,369	36,579,158	37,122,464	37,868,624
Other Medicaid Components	Medicare Buy-In	27,934,865	28,245,148	29,923,401	31,746,169
Core Medicaid	Children's Mental Health	69,796,119	74,418,448	80,176,948	86,307,986
Core Medicaid	Adult Mental Health and Chem Dep	42,937,084	44,635,611	46,793,976	49,101,620
Waiver	HIFA Waiver	7,100,000	11,395,951	11,623,870	11,856,348
Waiver	Disability Services Waiver	94,295,143	103,078,940	107,174,376	111,307,759
Federal Only	Indian Health Services - 100% Fed funds	47,604,512	51,891,103	56,554,535	61,628,200
Federal Only	School Based Services - 100% Fed funds	28,423,110	31,510,770	35,416,672	39,724,012
Federal Only	MDC & ICF Facilities - 100% Fed funds	9,896,811	10,096,811	9,521,578	9,521,578
Total	Total	$ 964,744,321	$ 1,014,590,474	$ 1,071,050,184	$ 1,127,748,022

CHRONOLOGY OF MAJOR EVENTS IN MONTANA MEDICAID

2013- A new integrated eligibility system for Medicaid, CHIP, TANF and SNAP was successfully launched in November 2012. This is one of the first systems of its kind and it has been identified by CMS as a model to emulate.

2012- A new MMIS was procured through competitive bid. The new system will replace a Legacy based system. It will be operational in 2015.

2012 – The Plan First family planning waiver was approved by CMS on May 30, 2012. Up to 4000 women of child bearing age will be eligible to receive family planning services.

2011- The Program for All Inclusive Care for the Elderly (PACE) program originally adopted in 2009 was eliminated by the Montana Legislature as part of the 17-7-111 5% reduction proposals. The PACE program transitioned the last person into other community alternatives and was sunsetted on June 30, 2011.

2011- Provider rate reductions were implemented by the Governor in 2011 to balance the budget in compliance with the trigger cuts mandated in17-7-140, MCA. These rates were not restored in 2012 and 2013.

2011- The state received approval to serve up to 800 people with schizophrenia or bipolar disorder under the 1115 "HIFA" waiver in December 2010. These people were previously served with 100% state funds and received no physical health benefits and more limited mental health benefits.

2009 – The Disabilities Services Division was renamed the Developmental Services Division and includes Children's Mental Health, the Developmental Disabilities Program, and Montana Developmental Center.

2009 – On January 1, the Developmental Disabilities Program received approval from CMS for the Children's Autism Waiver. Within the year, 50 children were selected and services were implemented.

2009 - On October 1, 2008 a new program was implemented to serve elderly Montanan's in a community setting. The Program for All inclusive Care for the Elderly (PACE) is a capitated managed care model that offers a comprehensive service delivery system and integrated Medicare and Medicaid funding. This program is exclusively for individuals 55 and older who live in Yellowstone County or Livingston and meet nursing facility level of care.

2008- The 2007 Legislature provided Medicaid funding to provide a rate increase when health insurance is provided for direct care workers in the personal assistance and private duty nursing

Worker program to cover the cost of premiums for health insurance that meets defined benchmark criteria.

2008- In fiscal year 2008 the department began claiming 100% federal match for tribal entities providing Medicaid funded personal assistance services. Currently the Blackfeet, Rocky Boy and Fort Belknap Reservations provide personal assistance services that are reimbursed at 100% federal match.

2008 - The Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, contracted Montana Tribes are able to be reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal MAM Cost Allocation Plan will give tribes a mechanism to seek reimbursement for the Medicaid administrative activities the Montana tribes now perform. Two tribes have taken advantage of this program.

2008 - The Hospital & Clinic program implemented the APR-DRG payment system and changed the ACS pricing methodology. On October 1, 2008, Montana Medicaid implemented a new inpatient reimbursement methodology for all hospitals, which is based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). In-state critical access hospitals will continue to be paid percent of charges using their cost-to-charge ratio. All other hospitals will be paid a prospective APR-DRG payment that reflects the cost of hospital resources used to treat similar cases.

2008 - On July 1, 2008 the Department submitted a Medicaid family planning waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. Upon approval from CMS family planning services are anticipated to be provided to about 4,000 low-income women of child bearing age. The waiver will decrease the number of unintended pregnancies, improve the overall health of enrollees, and save money for the Montana Medicaid program. This waiver was approved on May 30, 2012.

2008 - In June of 2008 a pared down Health Insurance Flexibility and Accountability (HIFA) waiver was resubmitted to the Centers for Medicare and Medicaid Services for their consideration. The targeted uninsured (those without physical health care coverage) populations to be assisted with Medicaid benefits were refocused to include 1,600 individuals receiving limited mental health benefits through Mental Health Services Plan, 200 youth with a Serious Emotional Disturbance that had aged out of the Montana Foster Care system, and 150 individuals to be assisted with the costs of affordable health care coverage through their ability to participate in the Montana Comprehensive Health Association Premium Assistance Plan. CMS approval to serve up to 800 individuals with schizophrenia or bipolar disorder was received in December 2010.

2008 - Increased the base wage rates for direct-care staff providing services to consumers with developmental disabilities and raised direct-care wages to at least $9.50 an hour.

2008 - The 2007 Legislature increased direct care worker wage to a minimum of $8.50 per hour, but in addition in SLTCD community based services was raised to $9.35 per hour and nursing homes to $9.20 per hour for certified nurse aides and personal care attendants. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2007 - Nursing facility provider tax was increased by $1.25 from $7.05 to $8.30 per day to fund nursing facility rates and services.

2007 - The eligibility requirements for pregnant women increased from 133% to 150% of the federal poverty level by legislative action.

2007 - The 2007 Legislature increased health-care provider rates, the increases vary across services and provider types, from a low of 1.39% to a high of 4.26%. The increases for SFY2007 generally began in October 2007 and the SFY2008 increases generally began in July 2008.

2007 - Home and Community-Based Services (HCBS) waiver for adults age 18 and over with severe disabling mental illness (SDMI), who without the waiver would be in nursing homes, was implemented. The SDMI waiver is available in certain core areas of the state and the surrounding counties. The waiver team in each core area consists of a nurse and a social worker who coordinates services provided to the covered individuals.

2007-Executed an agreement with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents. The agreement enables the Tribe to make Medicaid eligibility determinations on the reservation, reducing barriers or delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

2006 - Medicare Modernization Act implemented the Medicare Part D drug program that applied to approximately 16,000 Montanans who were eligible for both Medicare and Medicaid (dual eligibles). With the implementation of the Act, the dual eligibles will no longer receive prescription drug coverage through Medicaid, instead their prescription drugs are covered by a Medicare Part D plan. The Department is mandated to pay a portion of the drug cost through a Phased-Down Contribution (clawback) for dual eligible clients enrolled in Medicare Part D. Medicaid continues to cover barbiturates, benzodiazepines, smoking cessation drugs, prescription vitamins and the over-the-counter drugs for the dual eligibles as allowed in the Medicaid program.

2006 - The amount of assets a family can have and still qualify for children's Medicaid increased from $3,000 to $15,000 as a result of 2005 Montana Legislative action. Families must continue to meet income requirements to be eligible for children's Medicaid.

2006 - An amendment to the Developmentally Disabled Waiver occurred. The waiver serves people with significant support needs and the amendment expanded service options to include adult foster support, community transition services, adult companionship, assisted living and residential training support.

2006 – The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to the Centers for Medicare and Medicaid Services (CMS). The Waiver is intended to create a mechanism for Medicaid to pay for services that have historically been funded entirely with state dollars. This will allow the freed up state dollars to leverage additional Medicaid federal dollars.

2006 – The Deficit Reduction Act of 2005 (DRA) mandated certain Medicaid eligibility changes for people who are going to be institutionalized, reside in a nursing home or who are on a waiting list for a Waiver opening. The DRA eligibility changes include increasing the penalty look-back period from three years to five years for nursing home benefits for individuals who transfer assets at less than fair market value, with the look-back period changed to begin when the individual becomes eligible for Medicaid; new citizenship and identity verification requirements of applications for Medicaid; annuities owned by an ineligible or community spouse are considered countable resources for Medicaid applicants; the unpaid balance of a promissory note is considered a countable resource for Medicaid applicants; and the establishment of a $500,000 home equity exclusion limit for long term care applicants/recipients.

2006 – Direct care worker wage increase of $1.00 per hour for nursing facilities and community service providers were implemented utilizing I-149 funding. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2006 – Implemented a 3% provider rate increase to nursing facilities and community service providers utilizing I-149 funding.

2006 – Nursing facility provider tax was increased by $1.75 from $5.30 to $7.05 to fund nursing facility provider rates and services.

2005 - As a result of the Montana Health Care Redesign Project the 2005 Montana Legislature authorized DPHHS to revise the asset test used to determine children's eligibility for Medicaid and the submission of a Health Insurance Flexibility and Accountability (HIFA) Waiver.

2005 - Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and will be implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program will create a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

2005 - The first five year renewal of the Developmental Disabilities Community Supports Waiver occurred. The waiver offers a number of innovative and flexible service options for persons with limited support needs.

2005 – Nursing facility provider tax was increased from $4.50 to $5.30 to fund nursing facility provider rates.

2004 - Team Care program was implemented to targeted to people who over-use the Medicaid system. The program requires a group of identified Medicaid clients to enroll in the program and choose one primary care provider and one pharmacy to manage their health care. Clients will receive the professional care they need and have a team to help them decide how and when to access care.

2004 - Montana Health Care Redesign Project Report was published. The Project resulted from 2003 Montana Legislative action and was intended to examine the various options for redesigning the Montana Medicaid program. The Report was provided to the 2005 Legislature outlining the options that could be undertaken to redesign the identified health programs in a fashion that was financially sustainable into the future.

2004 – Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 – FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 – Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 – Children's Mental Health Bureau was created in the Health Resources Division.

2003 – Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 – Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 – Outpatient hospital reimbursement methodology was changed to Ambulatory Payment Classification (APC).

2003 – On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 – On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 – On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 – Increase cost sharing requirements for which the Medicaid eligible persons are responsible.

2002 – Began covering outpatient chemical dependency for adults.

2002 – Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 – Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 – July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 – Implemented a mandatory generic substitute policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 – Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 – Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 – Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 – Hospital Intergovernmental Transfers are implemented.

2000 – Prior Authorization was required in Personal Assistance Services.

1999 – Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 – Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed its name to Affiliated Computer Services – ACS).

1997 – Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.
1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 – Prior authorization was required of Home Health Agency services.

1996 – Federal welfare reform was passed on August 22, 1996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups (DPGs) to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana (FAIM), welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient psychiatric services was terminated by the legislature

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the federal poverty level. OBRA 89 stipulates that children are eligible for all medically necessary services.

1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1982 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

FEDERAL POVERTY LEVELS

Household Income at Federal Poverty Levels				
Percent of FPL	Household Size			
	1	2	3	4
34%	$3,798	$5,144	$6,491	$7,837
56%	$6,255	$8,473	$10,690	$12,908
100%	$11,170	$15,130	$19,090	$23,050
133%	$14,856	$20,123	$25,390	$30,657
138%	$15,415	$20,879	$26,344	$31,809
150%	$16,755	$22,695	$28,635	$34,575
200%	$22,340	$30,260	$38,180	$46,100
250%	$27,925	$37,825	$47,725	$57,625
2012 HHS Poverty Guidelines				

GLOSSARY OF ACRONYMS

ACS: Affiliated Computer Services

AFDC: Aid to Families with Dependent Children

AMDD: Addictive and Mental Disorders Division

APC: Ambulatory Payment Classification

CD: Chemical Dependency

CFSD: Child and Family Services Division

CMS: Centers for Medicare and Medicaid Services

CPI: Consumer Price Index

DD: Developmental Disabilities

DPGs: Day Procedure Groups

DRAMS: Drug Rebate Analysis and Management System

DRG: Diagnosis Related Group

DSD: Developmental Services Division

EFE: Essential For Employment

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FAIM: Families Achieving Independence in Montana

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level
FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HCFA: Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

HCBS: Home and Community Based Services

HCPI: Health Care Price Index

HCSD: Human and Community Services Division

HMO: Health Maintenance Organization

HRD: Health Resources Division

ICF/MR: Intermediate Care Facility for Mental Retardation

IHS: Indian Health Services

IMD: Intermediate Care Facility for Mental Disease

MCDC: Montana Chemical Dependency Center

MDC: Montana Developmental Center

MH: Mental Health

MHO: Mental Health Organization

MMHNCC: Montana Mental Health Nursing Care Center

MMIS: Medicaid Management Information System

MSH: Montana State Hospital

NDC: National Drug Code

NH: Nursing Home

OBRA: Omnibus Budget Reconciliation Act

PAS: Personal Assistance Services

PD: Physically Disabled

QAD: Quality Assurance Division

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

RVU: Relative Value Unit

SAMHSA: Substance Abuse and Mental Health Services Administration

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance (children and adolescents)

SFY: State Fiscal Year (July 1—June 30)

SLTC: Senior and Long Term Care Division

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families

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